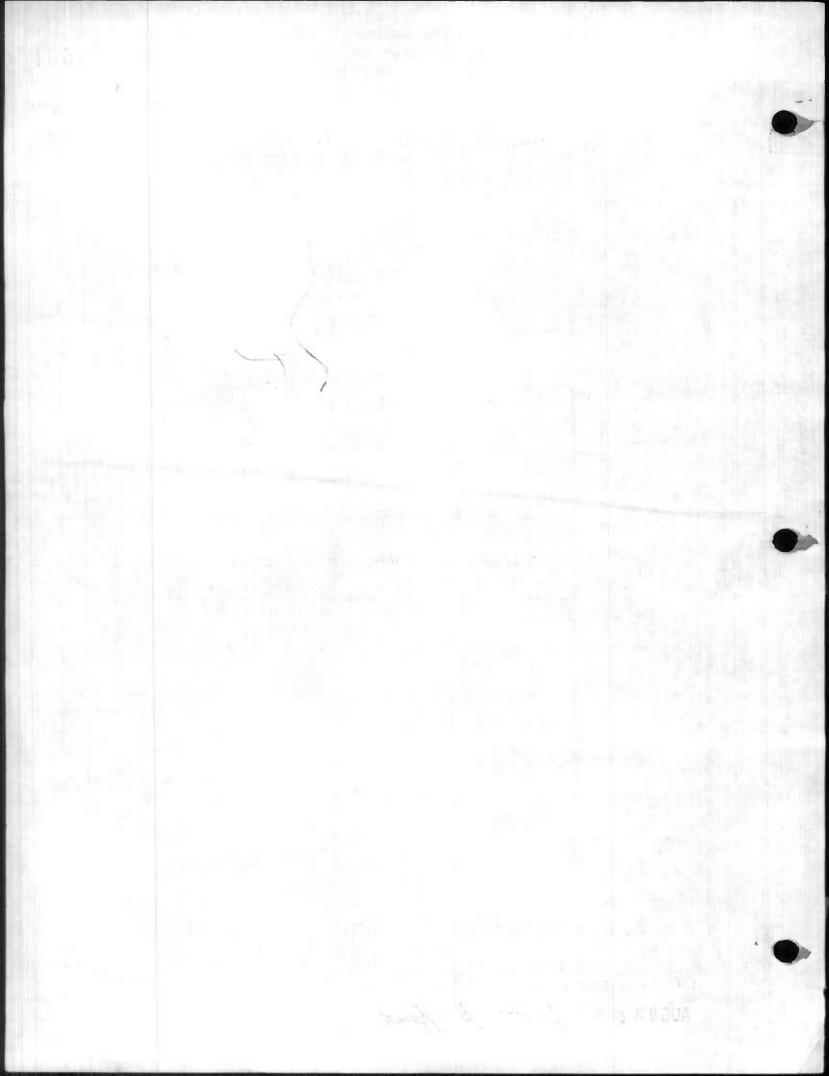
State of Maryland / Department of Health and Mental Hygiene 1 21,501

				Certifica	ite of	Death		Reg. No.	20 2	.4301
		1. Decedent's Name (First, Middle, Las	t)				2. Dete of De			3. Time of Death
	Physician /Medical	Stephen Teves					July	- 1	000	6:40pm
	Examiner	4e Facility Name (If not institution, give		Lan		46 City, Town, or L	ocation of Deal		more,	
) I I I	Franklin Square			er 1 Yeer	If Under 24 Hrs.				- Chate as Fassian
	Funeral Director	5. Social Security Number 6. Security Number 11 Sec	9X 7. Age (In yrs. 1	Yrs. Months		Hours Min.	8. Date of Bi (Month, D 7 / 7 / 4	8 Year)	Country	e (State or Foreign nia
	Mand Mand	10a. Stata 10b. County	10c. City	y, Town or Location						Inside City Limits
	r 28a-f ahow nout ed a	MD Balti	more Ba	ltimore						1 ☐ Yes X X No
	vith the Mai t or 28a-f a be notified	10e. Street and Number	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	10f. Z	Zip Code			10g. Citizen of	What Country	?
	th will rai C	9510 Belair Rd			212			USA		
Maryland 21215-0020	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or fleme 23a or 28a-f ahow int, the Master Esaminer must be notified at a Completed by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 10 Yes 2 □ No If Yes, Give Army Year or Dates:		edent of Foeding Cubo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	5 Specif	ce - Americen ck, White, etc y: Wh:	
5.0	be filed within 72 ho tal Hygiene. d other than "naturn event, pre Medical Be Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Us (Give kind of v life. DO NOT	ual Occup	eation during most of work	ing	16b. Kind of B	usiness/Indus	itry
1215-0	hen ne.	Elementery/Secondary (0-12)	College (1-4or 5+)					0	T.	al a. dount.
7 C	Hygle Hygle ther there the there the	17 years 17. Fether's Name (First, Middle, Last)	N/A	Master ted	chnic	18. Mother's Nam	e (First, Middle	Automot		dustry
and	Ba Se W	Joaquin Teves C	Cahral				Lara			
· Z	2 should I and Meni is marked sumatic	19a. Informant's Name/Relationship (7		19b. Mailing Addre	ss (Street			ber, City or Town	, State, Zip Co	ode)
	and 2 27 le	Estelle L. Osbo	ourn	9510 B	elai	r Rd, B	altimo	re, MD	2123	6
Casra	of Ha	20e. Method of Disposition	20b. P	lace of Disposition (Nemetery, crematory of	lame of	ce)	Dete	20c. Location	- City or Town	, State
S E	Pages nant of int: If Its	1 Burial 2 Aremation 3 4 Donation 5 Other (Specify	Hemoval from State	co_cremato			30/200	0 Balti	more.	MD
	permit. Page Department of Important: If any injury or poce.	21. Signature of Funeral Service Licen						sahn F		
m	89 5 5 8	C.J. Lassa	hn	1175	0 Be	alir Rd	. King	sville	, MD	21087
		23a. Part1. Enter the disease, or comp shock, or heert failure. List only	plications that caused the deet	h. Do not enter the m	ode of dyir	ng, such es cardiec	or respiratory	arrest,	fn	pproximate iterval Between inset and Death
1	Physician /Medical Examiner	Immediete Cause (Finel disease or condition resulting in death)	a. Brain Mass Due to (o	with Intro		anial bl	eed		3	Days
68760,	ificate be executed g physician and as the buriel-trensit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C	r as a consequence of					1	
Вох 68	E 000	resulting in deeth) Lest	d			163				
	es that the deeth cert igned by the ettendin be detached for usa by Physiclan/N	Part II. Other eignificant conditions co	ontributing to death but not res	ulting in the undertying	g cause gi	ven in Part I.	23b. Dfc	tobacco uee co	ontribute to the	he cause of death?
P.	d by t letach						10	Yee 2□ No	3 Probal	bly 4 X Unknown
Division of Vital Records, P.O	been s should					13.7		s en eutopsy formed?	24b. Were aveila comp of de	autopsy findings able prior to oletion of cause
Re	has be 2						10	Yes 2MNo		Yes 2□ No
面	cartificata ractor, pag	25. Was case referred to medical			*	26. Place of Dee				
<u> </u>	E 10 0	examiner?	Hospitel: 1 XInpatient 2	ER/Outpatient 3	DOA Ot	hor		sidence 6 🗆 Ot	her (Specify)	
0	g Physical distributions of Total	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injury occu	rred	
0	death. tor: After this the funeral the funeral	1 Naturel 5 Pending investigation		М		Yes 2□No				
Divis	tel or Attending P rs after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		ory, offica			(Street and Num own, State)	ber or Rural F	Poute Number,
	in 24 hours in 24 hours he Funer plately fill edical	29a. Certifier (Check only one) 12 Medical Exam	ysician: To the best of my kno iner: On the basis of examine and manner steted.	tion and/or Investigation	on, in my	opinion, death occu	, and due to the rred at the time	, dete end pleca	, end due to th	he cause(s)
	Within To the common on the co	29b. Signeture and title of certifier	P. ti	No.		se number		29d. Date sign		
	DO THE	Moune	ration 1			20347			- 27-	.00
	10	30. Name and address of person who o	completed cause of death (Item mer 9000 Fran	1 23a) (Type, Print) 1 Klin Squa	re D	rive Bal	timore	mDa	1287	
1	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture /						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day WAYNE NATHANIEL CAREY, JR. 22 2000 TITE 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) BETHESDA If Under 24 Hrs. NATIONAL NAVAL MEDICAL CENTER MONTGOMERY If Under 1 Year

Months

Days

16

Hours

Min

7. Age (In yrs. last birthday)

Yrs.

12XM 2□ F

7:40 AM

Birthplace (State or Foreign Country)

8. Date of Birth (Month, Day, Year)

July 6,2000 MARYLAND

Physician /Medical Examiner

Funeral Director

than "natural", or items 23s or the Medical Examiner must be filled willhin Pages 1 and 2 should be fill ment of Heelth and Mental H ant. If item 27 is marked olb lury or other traumatic even

Physician /Medical Examiner

Important: If its any inju-

Baltimore,

physician and the buriel-transit 98 USB ò signed by the e page 2 hes certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica director. funeral

in by

24 hours

To the I

Division of Vital Records.

Examiner Physician/Medical 2 Completed Be 0 Certification: edical

5. Social Security Number NA Usual Residence of Decedent 10s State 10b. County Directo 10e. Street and Number Funeral à Completed 0 Be 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in death) Last

10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No WESTMORELAND MONTROSS VA. 10f. Zip Code 10g. Citizen of What Country? 2514 ERICA ROAD MONTROSS VA. 22520 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Navar Marriad 2 ☐ Marriad 1 Yes 2 No Specify: AFROAMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) WAYNE NATHANIEL CAREY, SR. YVONNE RENEE PAIGE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE N. CAREY, SR. 2514 ERICA ROAD MONTROSS VA. 22520 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Salem Baptist Church 7/2700 MT. HOLLY VIRGINIA 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility BERRY O. WADDY P.O.BOX 305/6784 MARY BALL ROAD LANCASTER VIRGINIA 22503 Want 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feture. List only one cause on each line. Approximate tnterval Between Onset and Death SEPSI Due to (or as e consequence of) Due to (or as a consequenca of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2♥ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Wes an autopsy performed? complation of causa of death? 1 ¥ Yes 2 □ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide tti Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

ROBERT P. ENGLERT, LT, MC, USN 32. Registrar's Signature

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

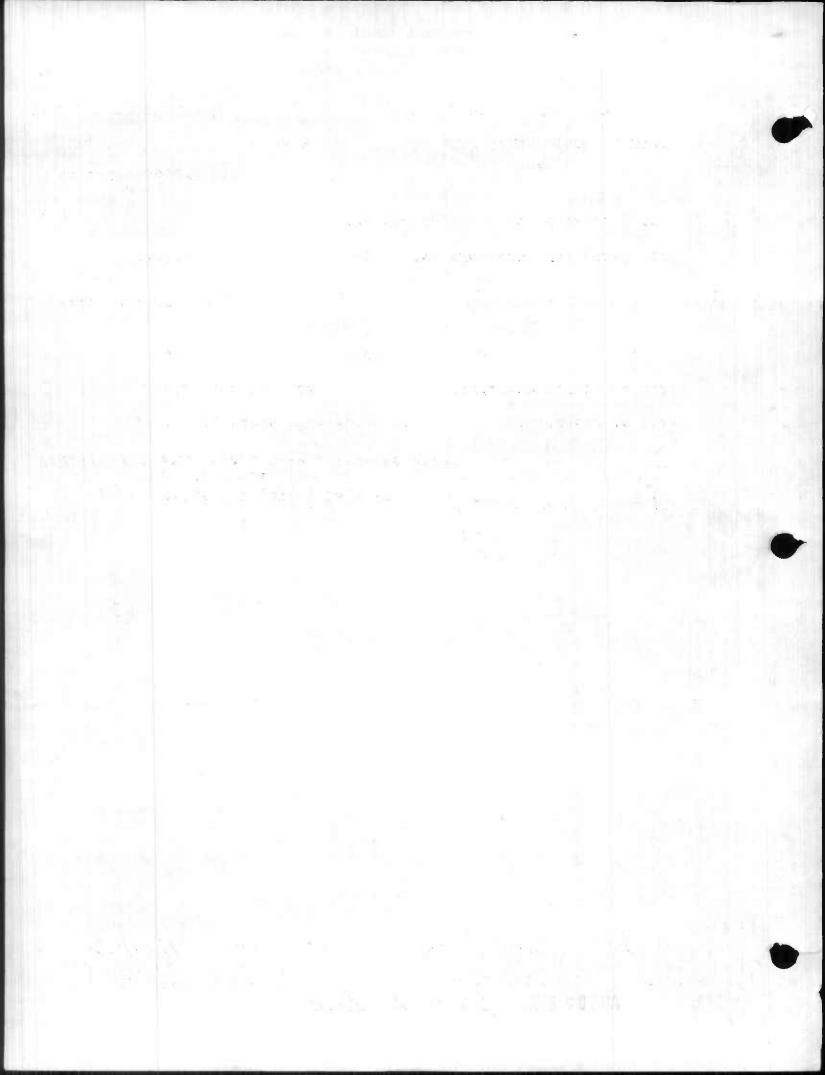


MD-060752-L (PA)

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

CENTER



State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

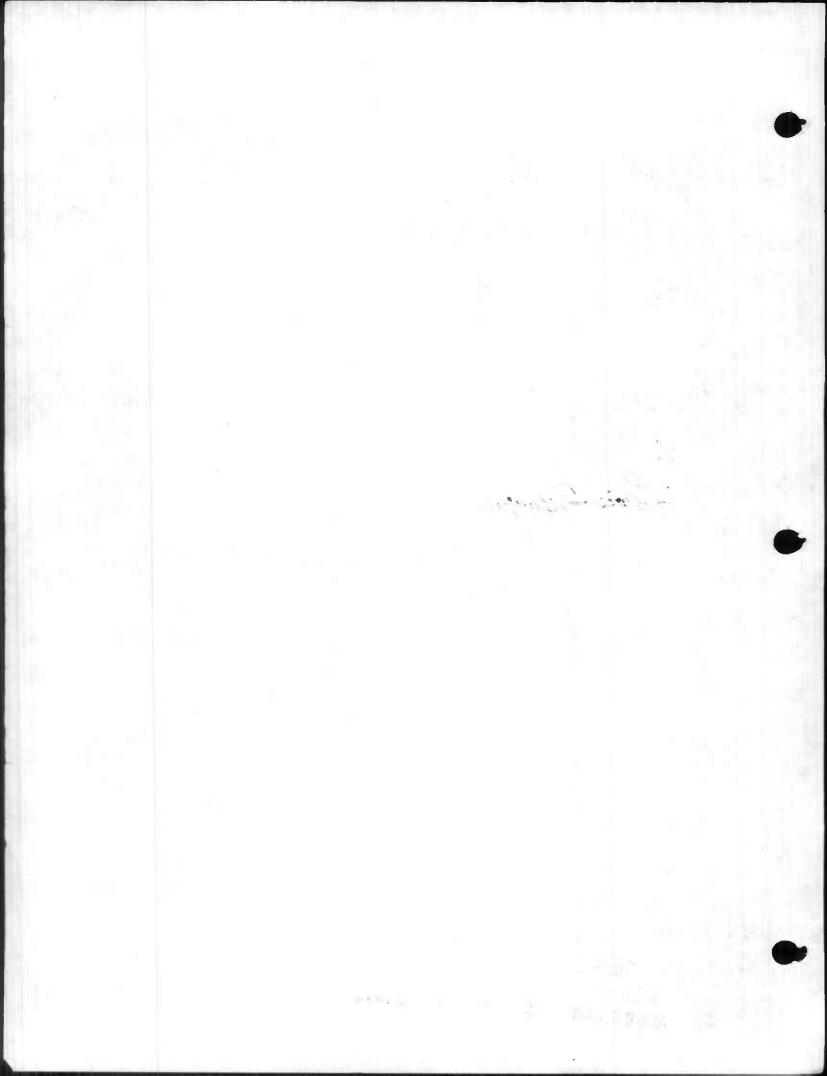
State of Maryland / Department of Health and Mental Hygiene 00 24503

Decedent's Neme (First, Middle, Last) MICHAEL LEE Fecility Neme (If not institution, give s Shock Trauma Social Security Number 13-76-6827 Just Residence of Decedent 1. Stete 10b. County N/A D. Street and Number	CROCKETT street and number) 7. Age (In)	yrs. last birthday)		4b. City, Town, or L Baltimo	ocation of Deeth	30°, 2000	of Deeth	Time of Deeth 11:57 ar		
Fecility Neme (If not institution, give s Shock Trauma coclal Security Number 13-76-6827 Just Residence of Decedent 10b, County MD MD N/A	7. Age (in s		5.11		ocation of Deeth	4c. County	of Deeth	11:57 ar		
Shock Trauma Social Security Number 13-76-6827 Well Residence of Decedent 10b. County N/A MD. N/A	7. Age (In)									
13-76-6827 X uel Rasidence of Decedent 1. Stete 10b. County MD . N/A	M 2□F 42					N/A				
MD . 10b. County		Z Yrs.	Months Dey		8. Date of Birth (Month, Day JULY	21, 195	Country	MD .		
. Street and Number	10c.	City, Town or Lo		3.1				nside City Limits		
3914 HUDSON ST			10f. Zip Code	21224		10g. Citizen of W	-			
Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:				pecify Yes or No- Rican, etc.)	Blect	- FALSE			
15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) Collega (1-4or 5+)	ine.	DO NOT use retil	red)	king					
12TH Father's Name (First Middle 1 set)		C	LII INS		e (First Middle					
				/						
19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1RENE CROCKETT 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3914 HUDSON ST., BALTIMORE, MD. 21224										
		cemetery, cra	matory or other p	IAL PK.	Dete 8/4/00					
	Selins	170	CHARLES	S. ZEIL	ER & S	ON, INC	C. E, MD.	21224		
quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or Injury t initiated events ulting in death) Lest	Deep Ve Injuries o	o (or es e conse	mbssis quence of):			mik,				
t II. Other significant conditions con	tributing to death but not	rasulting in the u	underlying ceuse	given in Pert I.	23b. Did tobacco use contribute to the cause of d					
							24b. Were e	utopsy findings		
							comple of deet	1000		
			701		/		1 M Ye	s 2□No		
examiner?	ospitel:		all 2004 C	ther.			(0!f-1			
Menner of Deeth 1 Natural 5 Panding 2 Accident invastigation	28a. Date of Injury (Month, Day Year	Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred				ed				
4 Homicida determined building, etc. (Specify) Street								ute Number, St. Munrca		
29a. Certifier (Check only one) 29b. Signeture and étite of certifier 29c. License number 29d. Date signed (Month Dev. Year)										
o. Signeture and title of certifier	1 Chuta									
	1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade lementary/Secondary (0-12) 12TH Fether's Neme (First, Middle, Last) ARNEST CROCKET Informent's Neme/Reletionship (Ty, RENE CROCKETT) Method of Disposition 1 Burial 2 Cremetion 3 R 4 Donetion 5 Other (Specify) Signature of Funeral Service Licenses A. Perfl. Enter the disease or complishock, or heart feilure. List only on mediate Cause (Final ease or condition utiting in deeth) auentially list conditions, ny, leading to immediate utiting in deeth) Wes cause referred to medical examiner? It initiated events utiting in death) Lest at II. Other significant conditions conditions conditions are conditions of the conditions	Table Tabl	1 Never Merried 2 Married 1 Yes, Give Yeer or Detes:	Tother significant conditions contributing to death but not resulting in the underlying ceuse of consequence of):	Tyes 2 No Specify: 1 Yes 2 No No Specify: 1 Yes 2 No Specify: 1 Yes 2 No	Types Agriculture Types Types	Type, were Merried 2 Married 3 Minder Groses? Type, 12/No. 1 Yes. 52/No. 5pecify: Specify Cubani, Marsiani, Puerio Ridan, etc.) Blace 1 Yes. 52/No. 5pecify: Specify Cubani, Marsiani, Puerio Ridan, etc.) 1 Yes. 52/No. 5pecify: Specify Cubani, Marsiani, Puerio Ridan, etc.) 1 Yes. 52/No. 5pecify: Specify Cubani, Marsiani, Puerio Ridan, etc.) 1 Yes. 52/No. 5pecify: Specify: Spec	Type, are Married Marr		

and a many constront

State of Maryland / Department of Health and Mental Hygiene 00 21,501.

		Certificate of Death	Reg. N	10.
Dhysisian	Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month	3. Time of Deeth
Physician /Medical	SHANITA CURRY			2000 01:31 A.M
Examiner	4e Facility Neme (If not institution, give street and number)	4b. City, Town, or Lo		Ic. County of Death
	University of Maryland Medica			N/A
Funeral Director	5. Social Security Number 212-02-2071 Usual Residence of Decedent	(est birthdey) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Dete of Birth (Month, Dey, Yea JUL, Y 14,	
ž 111		y, Town or Location		10d. Inside City Limits
at', or flems 23s or 28s-1 show Examiner must be notified at by Funeral Director	MD. N/A	BALTIMORE		Yes 2□No
funeral Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of Whet Country?
at D	1109 W. SARAHANN STREET	21223		U.S.A.
Je Je	11. Merital Status 12. Wes Decedent Ever in U.S. Armed Forces?	S. 13. Was Decedent of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
Examina by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes:	1 ☐ Yes 2 No Specify:	Thous, oto.,	Specify: BLACK
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
al du	Ejementary/Secondary (0-12) College (1-4or 5+)			
CO	12th N/A	CASHIER		ESTURANTS
B &	17. Fether's Name (First, Middle, Last)		e (First, Middle, Maid	an Sumeme)
2	ALLEN CURRY	BERNAD		DAVIS
other traumatic svent, ma Manager traumatic svent, ma Mana	19a. Informent's Neme/Relationship (Type, Print)	19b. Malling Address (Street end Number or Run		7 or Town, Stete, Zip Code)
	BERNADETTE DAVIS-MOTHER 20a. Method of Disposition 20b. Pl	1109 SARAHANN ST.		. 21223 Location - City or Town, State
	1 Burial 2 Cremetion 3 Removel from State	emetery, cremetory or other plece)		
any Injury or other tr once.	Donetion 5 Other (Specify) 21. Signeture of Foneral Service Learning	BUTUS MEMORIAL PK. 8 22. Name and Address of Facility	-5-00 AR	BUTUS, MARYLAND
attanding physician and local sea as the bunial-transit and local sea the bunial sea th	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	r as a consequence of): r as a consequence of):	OF	Interval Between Onset end Death
detached for use	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Pert I	23b. Did tobac	co use contribute to the cause of death?
hys			1 ☐ Yss	2™No 3 Probably 4 Unknown
by F				
			24a. Was en eu performed	? eveilable prior to
CI CL				completion of cause of deeth?
Com			1 Nes	2 No 10 Yes 2 No
Be (25. Was case referred to medical examiner?	26. Plece of Dea	th (Check only one)	
2	Hospital:	ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 □Other (Specify)
ino:	27. Manner of Death 1 Natural 1 Pending 28e. Dete of Injury (Month, Dey Year)	28b. Time of linjury at Work?	28d. Describe how in	ijury occurred
Certification:	2 Accident investigation 130/00	9:15 p.M 1 Yes 2 No	200	ect stabled
E	4 Homicide determined 28e. Place of Injury - Al ho building, etc. (Specify	ome, farm, street, fectory, office	City or Town, St	end Number or Rurel Route, Number, etc) 1423 Masker Strei
		end)	Baltin	note, aid.
edicai	(Check only Medical Examiner: On the basis of examinet	wiedge, deeth occurred et the time, date and plece, tion end/or investigation, in my opinion, deeth occur		
completely filled in by the funeral	29b. Signature and title of compar	29c. License number	29d. I	Date signed (Month, Dey, Year)
Nº	N. T. N	(A)		
1	30. Name and/address of person who completed cause of deeth (Item	O.C.M.E.		August 1, 2000
A	Toycoh Pes tanes	111 Penn Street, Bal	timore. Ma	arvland 21201
State	31. Dete filed (Worth, Day, Year) (32, Registrar's Signal	A COLOR		_1
State	2000 2 2000			



State of Maryland / Department of Health and Mental Hygiene

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						Certificate	e of l	Death	R	leg. No.	0 6	24000
	Physicia	an '	1. Decedent's Nama (First, Middle, La			11-31-3	10,		2. Date of Dea Month		Year	3. Time of Death
	/Medic	_	Anna P. Davis						July		000	10:25 AM
لر	Examin	er	4a Facility Name (If not institution, giv	1 1 1	edical C	enter	4	Baltim		4c. County	of Death	
H	Funeval		5. Social Security Number 6. S		(In yrs. last bir	thday) If Under		If Under 24 Hrs.		N/A	9. Birthp	olaca (Stata or Foreign
	Funeral Director			□M 2F		Yrs. Months	Days	Hours Min.	8. Date of Birth (Month, Day	1 949	Coun	st Virgini
	8 .		Usual Rasidanca of Decedant 10a. State 10b. County		10c. City, Tow	n or Location						
	shoy and at	50	MD N/A		Balti							0d. Inside City Limits 11☑ Yes 2☐ No
	with the Marylan s or 28a-f show be notified at	Director	10e. Street and Number		Dares	10f. Zipi	Code			I0g. Citizen of W	/hat Cour	21
	23a or	ā	1326 Washingto	on Blvd.		1000		230		USA		
	3 25	neri	11. Marital Status	12. Was Dacedant E Armed Forces?	Evar in U,S.	13. Was Deced	lent of H	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yas or No-	14. Race		ean Indian,
21215-0020	raf, or its Examiner	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1 Yes 2		Specify:	rnoan, etc.)		k, White, o	
5-0	72 h	eted	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usua (Giva kind of wor	k done	during most of worl	king	16b. Kind of Bu	siness/Inc	Justry
121	William Da Ma	Compl	Elemantary/Secondary (0-12)	Collega (1-4or 5		life. DO NOT us		0		C1200	Col	m > 3 > 1.
	Hygin Hygin Hygin Mark		17. Fathar's Nama (First, Middle, Last))		Secreta	ГУ	18. Mother's Nam	e (First, Middle,	Glass Maiden Sumam		apany
land	fental feed of fic ev	To Be	Samuel Luther	Case				Mildre	d Meyer	s		
any	on and a		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (3					and Number or Ru	rai Route Numbe	r, City or Town,	Stata, Zip	Code)
Σ.	and 2 n 27 in		Dawn Dix					gton Bl				
more	or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removai from State	20b. Place o cemete	f Dispositi <i>on (N</i> am ry, crematory or of	ne of ther plac	e)	Date O /	20c. Location -	City or To	wn, State
Ę	timen tamt: yory		4 Donation 5 Othar (Spacif	y)	Chesa	peake (matory	8/05/00	Belts	vil:	le, Md.
Bal	Department of the partment of		21. Signatura of Fundral Service Licar	Somo			. K	aufman :				eadowridge
			23a Part Erler the disease, or come shock or heart failure. List only	piications that caused one cause on each iir	the death. Do	not enter the mode	e of dyin	g, such as cardiac	or respiratory arr	est, IKric	ge,	Approximate Interval Between
	Physician											Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition rasulting in death)	a sepsis								Iday
		ē			The second	consequenca of):	,				i	3 years
	outed ansit	Examiner	Sequentially list conditions	b. ISchemic		consequence of):			ALL POR		1	Sylary
0,	tificate be executed g physician and as the burial-transit		Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury									
68760,	hysic the b	edical	that initiated events rasulting in death) Last	c.	Due to (or as a	consequence of):					1	
9 x	5 0 4			d								
Box	death cert e attending ed for use	clan						100.52			- 1	
P.O.	that the de ed by the detached	ysk	Part II. Other significant conditions of	ontributing to death bu	it not resulting i	n the underlying ca	ause giv	en in Part I.	23b. Dld to	/		the cause of death?
	that the ned by a detact	y Pt	vulvor cancer						ושטו	es 2 No	3 Prot	bebly 4 ☐ Unknown
rds	w requires that the been signed by the should be detache	Completed by Physician/N	diabetes						24a. Was a			ere autopsy findings allable prior to
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Œ.	iclan: The lav certificate has rector, page 2	Com	congestive hear	t failure					1 🗆 Y	es 2 No	10	□Yes 2□No
/ita	yalclan: is certifical director,	Be	25. Was case referred to medical axaminer?					26. Place of Dea	th (Check only o	na)		
of	Physic this co	10	1 Yas 2 No	Hospital: 1 Inpatier				4 U Nursing H	oma 5 Resid			מ
no	After funer	tlon	27. Manner of Death 1 Natural 5 Pending invastigation	28a. Date of Injur (Month, Day	Year) 285.	Fime of 29 njury M	8c. Injur Wor	yat k? Yas 2 □ No	280. Dascribe n	ow injury occurr	90	
Division of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not b		irv - At home, fa	rm, street, factory		183 2 0110	28f. Location (S	treet and Numb	er or Rure	al Route Number,
Š	after after din t	enti	4 Homicide	building, afc	. (Specity)				City or Tow	n, Stata)		
	hours meral y fille			yelclan: To the best o								
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination an							
	To t To t	2	29b. Signature and title of certifier					a number		29d. Data signed		
	10		P clype Mure	lor			14171	435 M130	83	JULY 3	50,	2000
(Mary		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	1 2	11th medice 1	10 21217)		
			31. Date flied (Month, Day, Year)	10 W. North	Signature		, DC	ATTIMOTE, N	TU LICIL			
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			State of	Marylar		irtment of F tificate of	lealth and I Death		Reg. No.	0 2	24506
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/Medi	_	John Howard E					4b. City, Town, or I	July	30	2000	3:04a.m
Examir	ner	4a Facility Name (If not institution, giv Fallston Gen			- 1	119	Fallsto			y of Death	4
Funeral		5. Social Security Number 6. S		•	last birthday)	If Under 1 Year	If Under 24 Hrs.	P Date of P	ieth	oforo	place (State or Foreign
Funeral Director			M 2□ F	68	Yrs.	Months Deys	Hours Min.	2/7/1	932	Washi	ington DC
9 .		Usual Residence of Decedent		1.0- 0:							0.1 1-12-0.11-2-
with the Maryland a or 28a-f show Lbe politied at	50	10a. Stete 10b. County			ty, Town or Lo	Cation					1 ☐ Yes 2 🕅 No
176 M	ect	MD Baltin	ore	Ra	ldwin	10f. Zip Code			10g. Citizen of	What Cou	ntry?
The or	O	13575 Fork Road				210	13	ua N	US		
death ms 2	Funeral Director	11. Merital Status	12. Was Decede	ent Ever in U	I,S. 13. V		dispanic Origin? (S an, Mexican, Puert	pecify Yes or N			can Indian,
15-0020 72 hours after death with the Marylar "natural", or items 23e or 28e-f show odicel Examiner must be notified at		1 Never Merried 2 Married						o rican, etc.,	Speci		
21215-0020 within 72 hours after ens. then "netural", or the he Medical Examina	d by	3 Widowed 4 Divorced	Year or Date	sKorear	contino	Yes 2 No				AMIC	
21215-0020 d within 72 hours at plenn t then "nehural", or the Medical Exem	Completed	15. Decedent's E- (Specify only highest gra	ide completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of E	susiness/in	dustry
212 212 212 21 milit	mo	Elementary/Secondary (0-12) 12 years	6 years	or 5+)	Distric	t manager	engenier		Bell Atla	entic	
	8	17. Father's Neme (First, Middle, Last			•		18. Mother's Ner			me)	
ylar Monta	To	Frances Howard	Edwards	3			Joseph				
Maryland d2 should be file th and Montal Hy 7 is marked othe traumatic event		19a. Informant's Name/Relationship (* '				and Number or Ru				o Code)
2 T N L		Charlotte Edwards (wi	Te)	20b. I		Sition (Name of	Rd. Balo	Date	20c. Location		own. State
Baltimore, semil. Pages 1 a Department of Hea mportant: If them my injury or othe ange.		1X Burial 2 Cremation 3		ate	cemetery, cren	natory or other pla	metery				
Baltim semit. Pa Separtmen mportant my injury MSB.		4 ☐ Donetion 5 ☐ Other (Special 21. Signature of Funeral Service Lices		110		. Name and Addre	-	0/0/00	Daioi	111010	, 110
S FORES		16 to Law	do				ahn Fun				
		23a. Part1. Enter the disease, or com shock, or heert failure. List only	plications that cau	sed the dea	th. Do not ent	1750 Be er the mode of dyi	lair Rd	. King c or respiratory	sville arrest,	, MD	21087 Approximate Interval Between
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/Medical Examiner		Immediate Cause (Finel disease or condition	P	neu	inom	9					10 Days.
Lamine	2	resulting in death)		Due to (or as a consec	uenca of):					2.158936
Death Insit	Examiner		b. —	0			9			i	
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thet thet	y Pt	Respirator	1	ei (c	ere			1	Yes 21110	3 Pro	Debty 4 Unknown
DIVISION Of VITAI RECORDS, P.O. BOX 6 or Attending Physician: The law requires that the death certificate has been signed by the attending principar. After this certificate has been signed by the attending prin by the funeral director, page 2 should be detached for use as	Completed by Physician/M							24a. Wa	s an autopsy formed?	24b. W	ere autopsy findings vailable prior to
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Affer funer	lon	27. Menne of Deeth 1 Netural 5 Pending 2 Accident Investigatio		Day Year)	28b. Time of Injury	Wo	ryet rk?]Yes 2 ☐ No	28d. Describe	how injury occu	Irred	
DIVISION or Attending after deeth. Director: After	fical	3 Suicide 6 Could not b	00- 01	tnjury - At h	ome, farm, str	eet, factory, office	, 100 2 2 100	28f. Location	(Street end Nun	ber or Ru	ral Route Number,
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the H the E the F	Medical	one)	and manne		SHOT BILDOT III			or the tane			
To the within To the comple	2	29b. Signature end title of certifier	6. 5	ND		29c. Licens	53720		29d. Date sign ②干[3]]		, Day, Year)
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1 mx	\	30. Name end eddress of parson who	completed cause	or death (Ite	m 23a) (Type, Rel S	Print)	feetls	ton,	mo.	2104	-7-
Sta	ite	31. Dete filed (Month, Day, Year)		istrar's Sign				-			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMONTH Year 11:30 A.M 2000 Emma J. Foy 4b. City, Town, or Location of Death 4a Facility Name (II not institution, give street end number) 4c. County of Death North Arundel Hospital Glen Burnie If Under 24 Hrs. 8. D. Hours Min. (A Anne Arundel If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days 1 M 2 F Months 80 Yrs 059-16-1398 Nov. 11. 1919 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 840 Swift 21122 Road USA 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Yes 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: specify: White 3 ☑ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Food Service Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank Dean Lucy Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wayne Foy - Son 842 Swift Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 4 Glen Haven Cemetery Glen Burnie, MD 22. Name and Address of Facility 21 Signature of Funeral Service Hounts Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one ceuse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, CORENTO VASCULAR ACCUSENT Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of de 4 Unknown 3 Probably 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Many er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

mas 23a or 28a-f show

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Physician/Medical

Be Completed by

Peges 1 and 2 should be filed within nent of Health and Mentel Hygiene.

Baltimore, Maryland

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filed within 72 hours after

Medical Certification: To funeral After within 24 hours after deeth. To the Funeral Director: A filled in by Hospital completely ş 0

29b. Signature and title of certifier

Registrar

State

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

Cilen Burne.

29d. Date signed (Month, Day, Year)

2000

Location (Street end Number or Rural Route Number, City or Town, Stete)

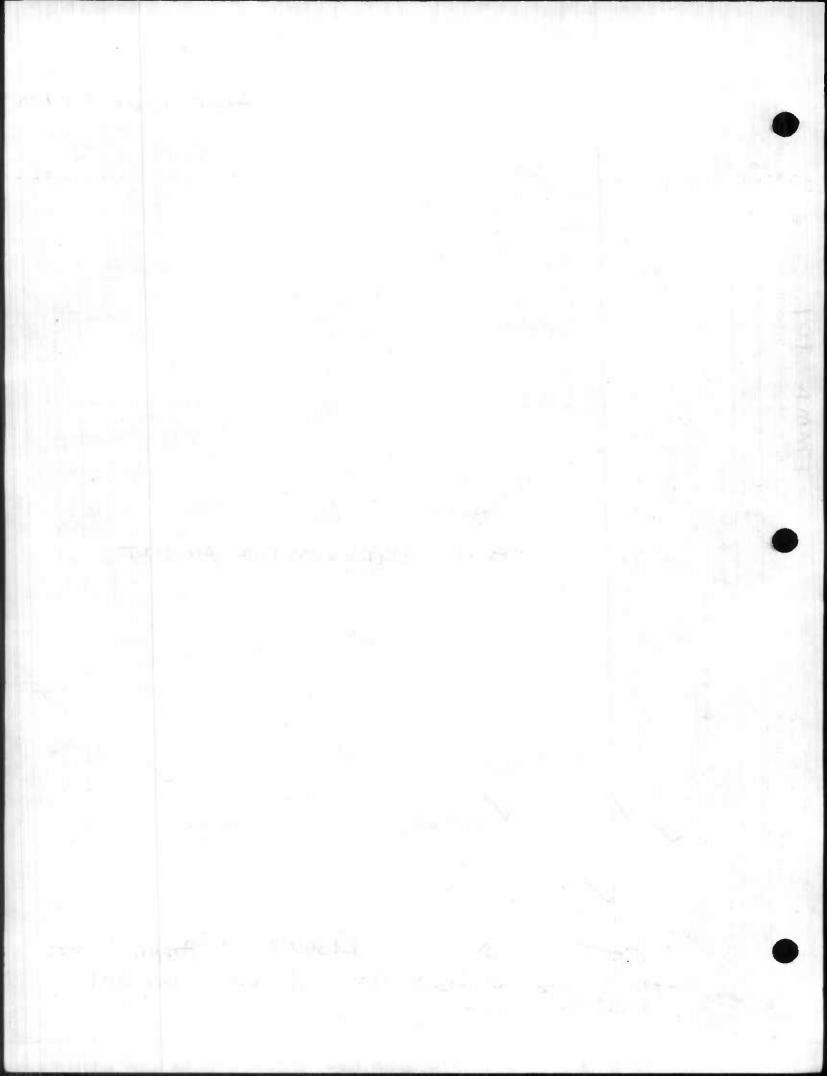
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

6 Could not be determined

Drive. 301 Registrar's Sign

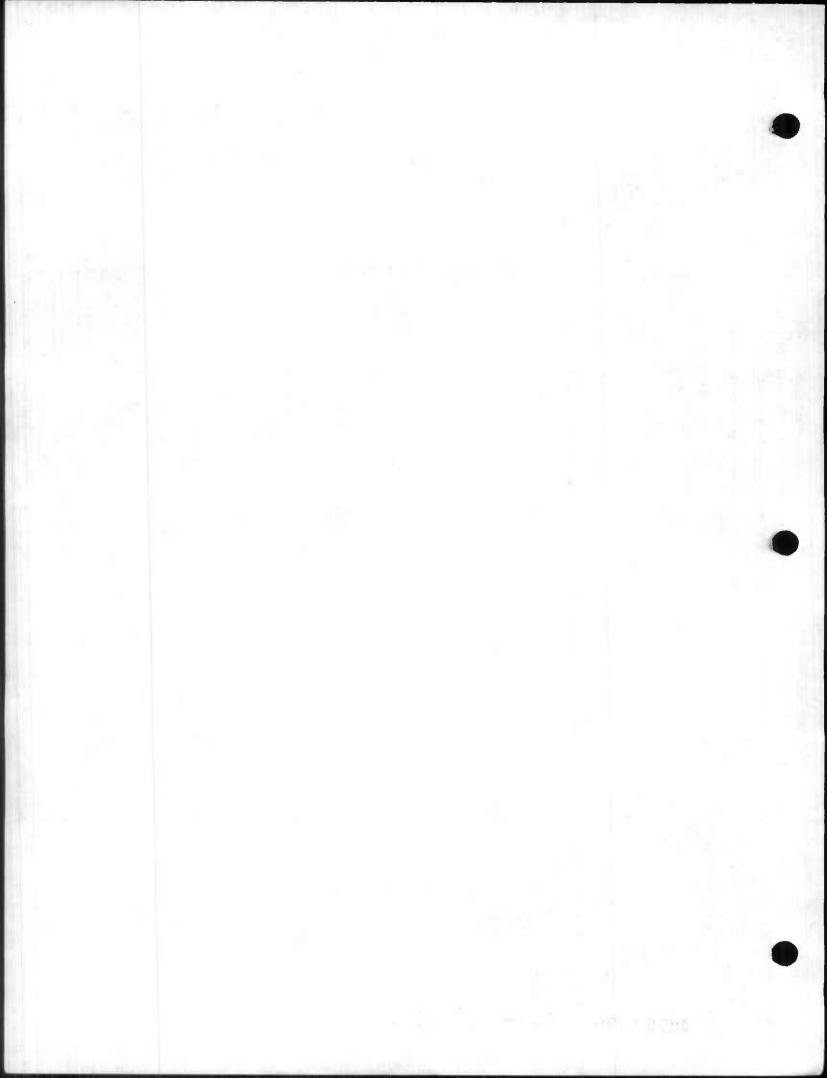
Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and menner steted.



State of Maryland / Department of Health and Mental Hygiene

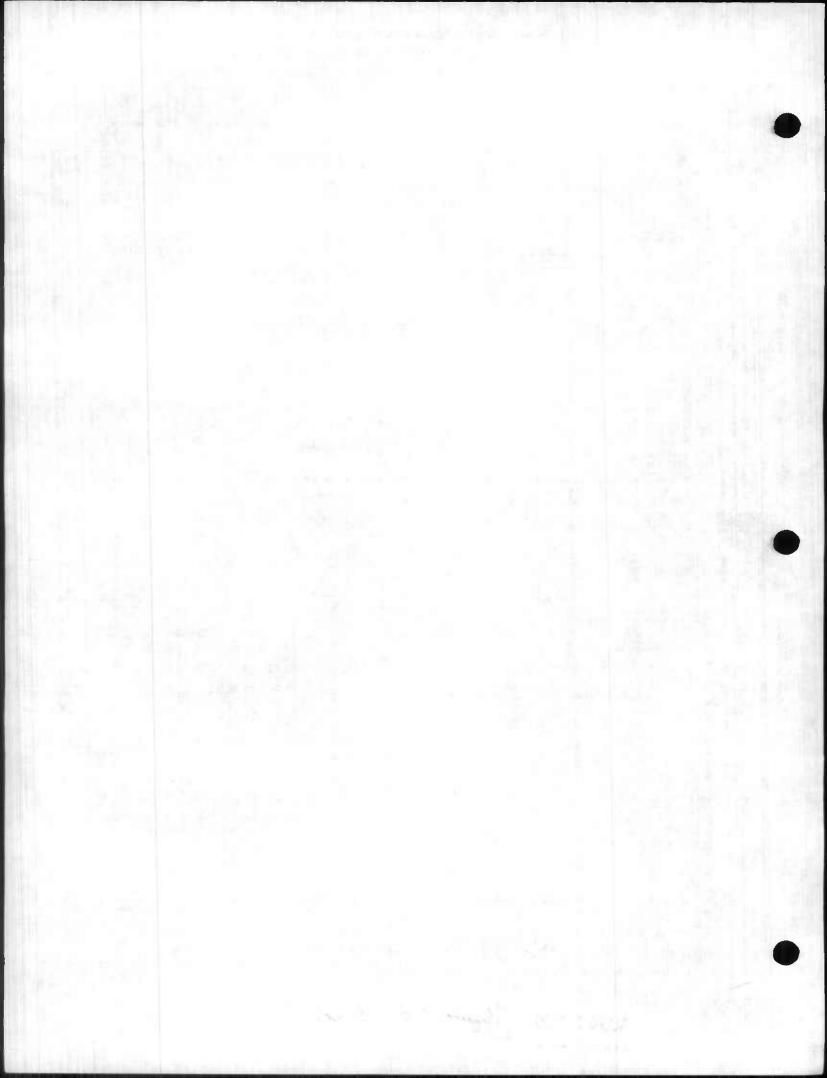
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/Medical Examiner	4e Facility Neme (If not institution, give	street and number)			4b. City, Town, or	1		
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Funeral Director	5/8-54-5081		n yrs. last birthday) 59 Yrs.	If Under 1 Year Months Deys		8. Dete of Birt (Month, De January	y, Year) 8,1941	9. Birthplece (State or Foreign Country) Springhope,
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led a	District of Columbi	La	Washingto	on'				1 Ñ Yes 2 □ N
a or 28a-t sh at be notified if Director	10e. Street end Number 1802 Benning Road	NE		10f. Zip Code 20002			10g. Citizen of V .S. Ame	
Examiner must Examiner must I by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yea 2 No If Yes, Give Year or Detes:		Wes Decedent of If Yes, specify Cut 1☐ Yea 2☑ No	Hispanic Origin? (S ben, Mexican, Puerl Specify:	pecity Yes or No- o Rican, etc.)	Blec	e - American Indien, k, White, etc. : Black
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Department important any Injure and Sec.	21. Sometion of Funerel Service Licens		2.	2. Name and Addr	1	pert G.	Mason Fu	ineral Home
trending physician and for use as the burial-transit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	e to (or es e conse END STA e to (or es e conse ASPRENTO e to (or es e conse STE C	quence of):) <u>.</u>			
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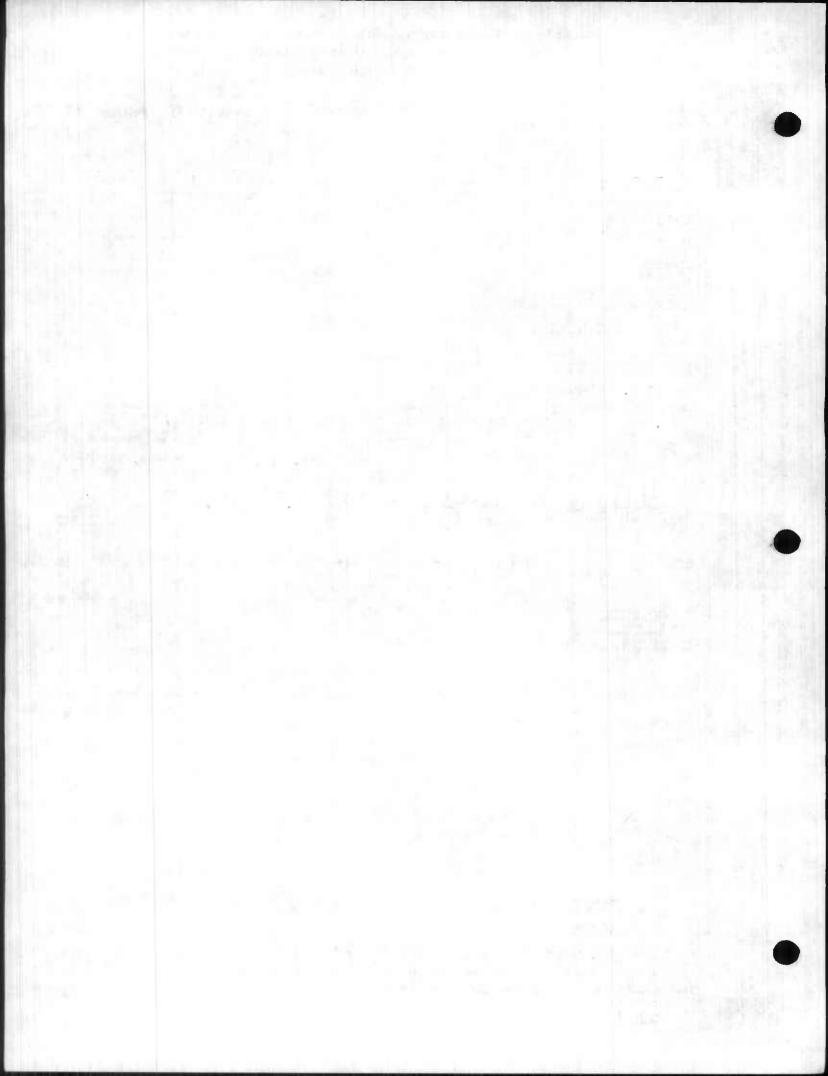
State of Maryland / Department of Health and Mental Hygiene 00 24510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 5:35 AM FLYNN august 2000 MARTHA 01 /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner N/A BAYVIEW JOHNS HOPKINS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Dete of Birth (Month, Dev. Year) **Funeral** 1□M 2/2 F Yrs. Director 379-28-2633 Michigan Usual Rasidence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at Fennville 1 Yes 2 No Directo Allegan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Hems 23s United States 49408 2110 Lakeshore Drive Funeral 14. Reca - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Yes 2 No It Yes, Give Yeer or Dates: 1 Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 Yes 2€ No Specify. Specify à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Own Home Homemaker 12 Years 6 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnema) marked of should be Margaret Wheelock Carl F. Anderson and a 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Pages 1 and 2 Mr. Leo Martin Flynn (Husband) 2110 Lakeshore Drive Fennville, MI nt of Health : 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Hilltop Service Corp. 8/2/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the seal shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final PANCREATIC TWO MONTHS disease or condition rasulting in death) Examiner Dua to (or as a consaquence of) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last Due to (or as e consequence of) P.O. Box 68760. use as the Due to (or es e consequença of) t or Attending Physician: The lew requires that the de-after death.

Director: After this certificate hes been signed by the a din by the funeral director, page 2 should be deteched if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Wera autopsy tindings 24a. Was an autopsy available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No Certification: 27. Mannar ot Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Tertifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. Medical 29a. Certifier 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) RES-000 01,2000 AUGUST 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) VANDANA REDDY, MD 600 North Wolfe Street Baltimore, MD 21287 31. Date filed (Month, Dey, Year)
AUG 0 3 ZUUU 32. Registrar's Signatur State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24511 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth Year DOROTHY GRACIE 400 Am AVEUST 0005 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Mariner Health of Laurel Prince George Laurel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign 1 □ M 2 🕽 F 139-22-2906 92 Yrs 01-26-1908 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George Laurel 1 ☐ Yes 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12002 Orvis Way 20708 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Black White etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ♥ No Specify: white 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Salesperson Fabrics 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) LOuis Lichtenstein Edith May Wood Hodgson 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 12002 Orvis Way Laurel, Maryland 20708 Particia Gracie daughterinlaw 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 8-4-00 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge, Maryland 22. Name end Address of Fecility Fleck Funeral Home Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 and division, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, and failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting In deeth) PROSPORTE PENTE MYDERNAGE NARION A CVIE Due to (or es e consequence of): COS SC 570815 Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OSTEOMITUROUTS 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed?) FPRESSION 1 ☐ Yes 25 No 1 Tyes 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2€ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

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Physician

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7 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Modical Examiner must be notified at

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Department of Heal Important: If Item 2 any injury or other once.

Physician

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Baltimore, Maryland

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Registrar

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Medical

31. Dete filed (Month, Dey, Year) AUG 0 3 2000

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30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end manner steted.

29c. License number

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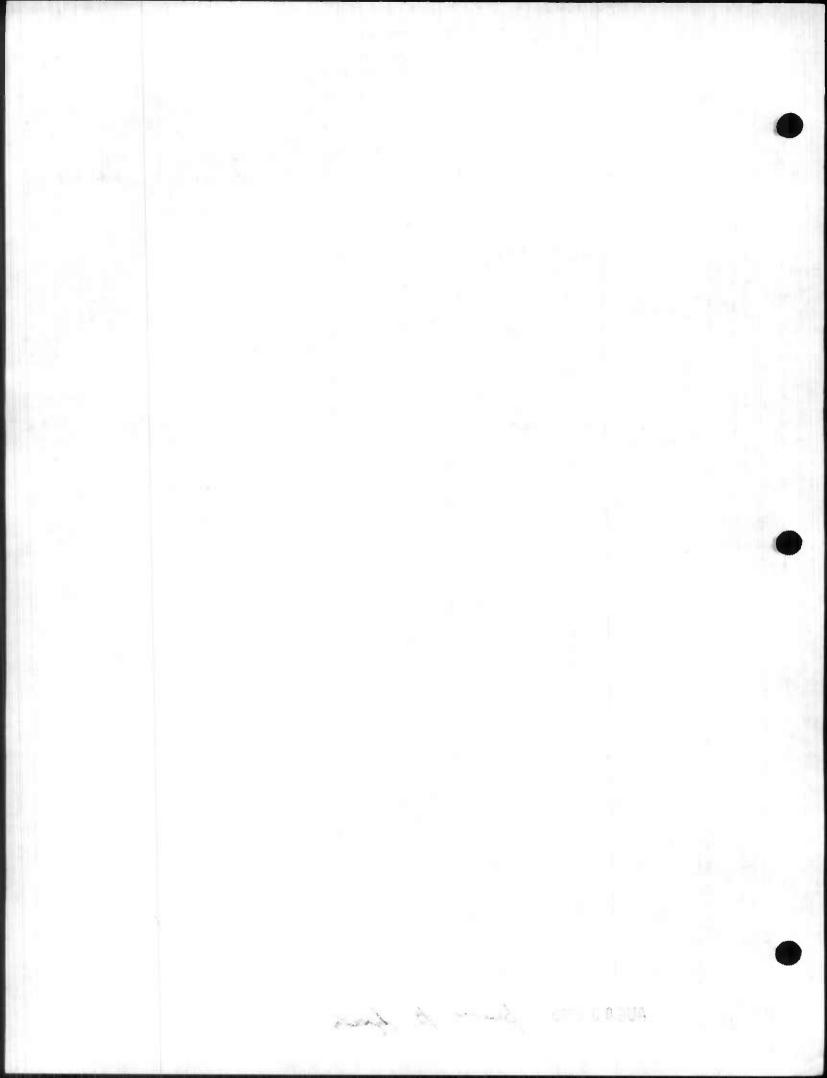
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State of Maryland / Department of Health and Mental Hygiene

24512

							-						Reg. No.			
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sician				1	Mary H	Ellen	Galla	gher				July	29	200		:20 A.M
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permit. Peges 1 and 2 sn Department of Health end Important: If Item 27 Is m any Injury or other traum ance.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, 2									te, Zip Code	9)				
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		Ama M Jramesoushi 4001 Ritchie Highway Baltimore, Md. 21225											0.5			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4s Eacility Name (If not institution, give street and number) Examine 20 ure 2 of If Under 1 STOWN a Imore 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min 1□M 20 F 577-46-6419 Usual Residence of Decedent Director 430uth arolina 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flame 23a or 28a-f show traumatic event, the Maxical Examinor must be northed at 1 Yes 2 No Directo Maryland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Funeral filed within 72 hours after deeth . Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race 13. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Year or Dates Hmerican 1 can Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) lnion om permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: if item 27 is marked other any injury or other traumatic access 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Intermant's Name/Relationship (Type, Print) (Daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ,Md,21040 ewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal trom State 4 ☐ Donation 5 ☐ Other (Specify) 10 Gardens emorial 21. Signature of Funeral Ser/Ice Liqui 22. Name and Address of Facility Joseph L. Russ Fu 2222 W. North Ave. plications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cancer Examiner Due to To as e consequence ot): Physician/Medical Examiner The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No λq page 2 should Be Completed 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? 20 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese reterred to medical 26. Place of Deeth (Check only one) Other: 2 NO 4 Nursing Home 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28b. Time of 28d. Describe how injury occurred Certification: Injury et Work? 5 Pending investigation 1 Delurel ours after deeth. eral Director: Aft filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) While D 4768 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Raymond Millor

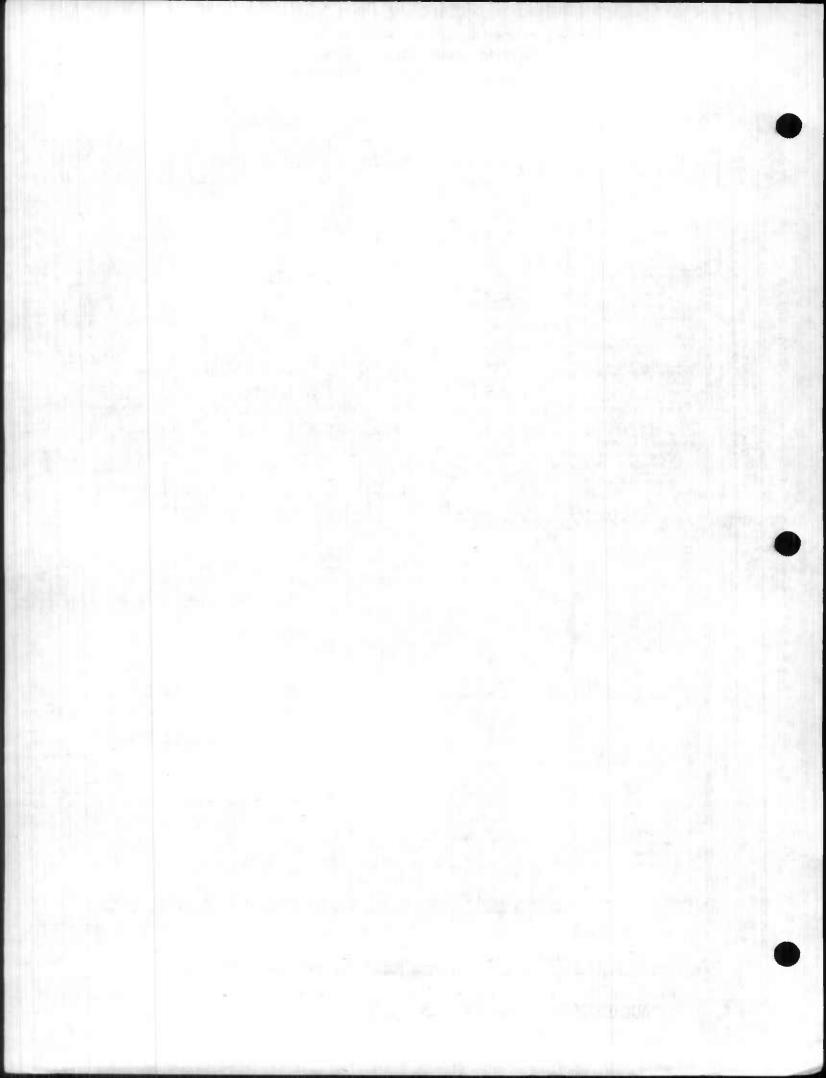
31. Date Gilby (UG 03 Y 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician 31, 11:27pm Leroy Nelson Harris Jr. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice Baltimore N/A 8. Date of Birth (Month Pay, Year) 1960 If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)

Maryland **Funeral** M 2DF Hours 214-76-0248 40 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2805 Waldolf Avenue 21215 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 'natural', or 1 Yes 2K No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HARRI 12th Packer Ice Cream 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 and Mental Leroy N. Harris Sr. Norma L. McDuffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If fem 27 is a say injury or other Shirley D. Williams (Sister) 2805 Waldolf Avenue Baltimore, Maryland 21215 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 08/05/00 Lansdowne, Maryland 22. Name and Address of Fecility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervet Between Onset and Death **Physician** mmune Deficancy Disease /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physicien a the burial Due to (or es a consequence of) Box (P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by id 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attanding Physicien: Within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; p 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Division 1 Matural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number o lell 8-1-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 N. Entaw St. Bar Hs. Md 21201 ITY WINMED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State beneve & Roads

DHMH 16 Ray 6/95

Registrar

AUG 0 3 2000

- 110 G B 2110

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amended item #19a per fh g786 8-3-00 wij 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** MILTON HOUSE 0645 2000 JULY 30 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NESCH HOSPITAL SACTIMORE 8. Data of Birth Month, Dex. If Under 24 Hrs. If Under 1 Year 9 Birthplece (State or Foreign 5. Sociel Security Number 7. Age (In yrs. lest birthday) 10 M 2□ F Deys Min. 20 Yrs. Director Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow the Medical Examiner must be notified at Maryland 1 Yes 2 No Director nor 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2 Funeral Hema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indien, Black, White, etc. 11. Marital Status filed within 72 hours after. Hyglene. other than "natural", or its 1 ☐ Yes 2 No If Yes, Giva Yeer or Detes: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled we Department of Health and Mental Hyglen important: if item 27 is marked other thy any injury or other traumatic event, the once. 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middla, Last) Be 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) mother 2/2/ 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition /Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 12000 Greenmount remator 22. Name and Address of Facility / Joseph Hom 5 -uneral 2222 WiNorth 1216 Aver 23a Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceusa (Final disease or condition resulting in deeth), Sepsis /Medical weeks Examiner Due to (or as a consequence of): weeks Examiner te appendi Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last and attending physician for use es the buna P.O. Box 68760. Physician/Medical tha Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably > ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en autopsy performed? **Be Completed** page 2 s certificate has 2 NO 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending Investigation Natural after deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Streat and Number or Rurel Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a Certifier 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL 301 55

Sa

31. Dete filed (Month, L Day, Year) State Registrar

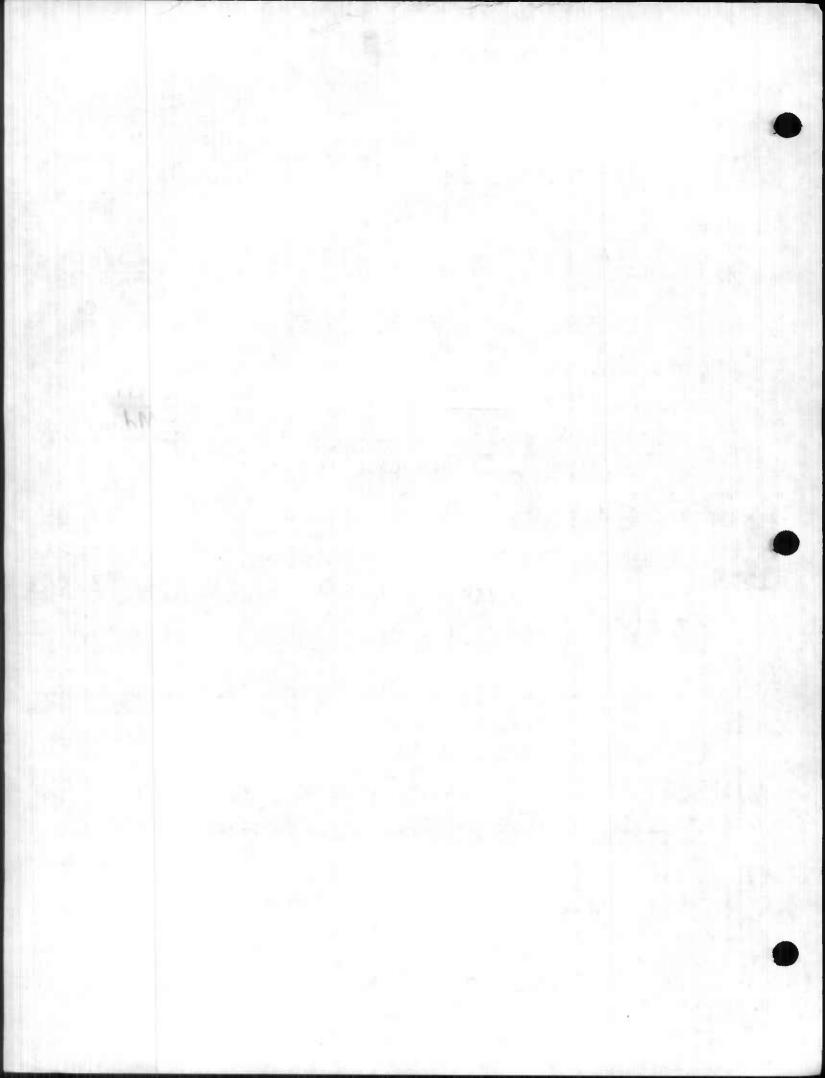
29b. Signeture and title of cartifier

32. Registrer's Signature

29c. License number

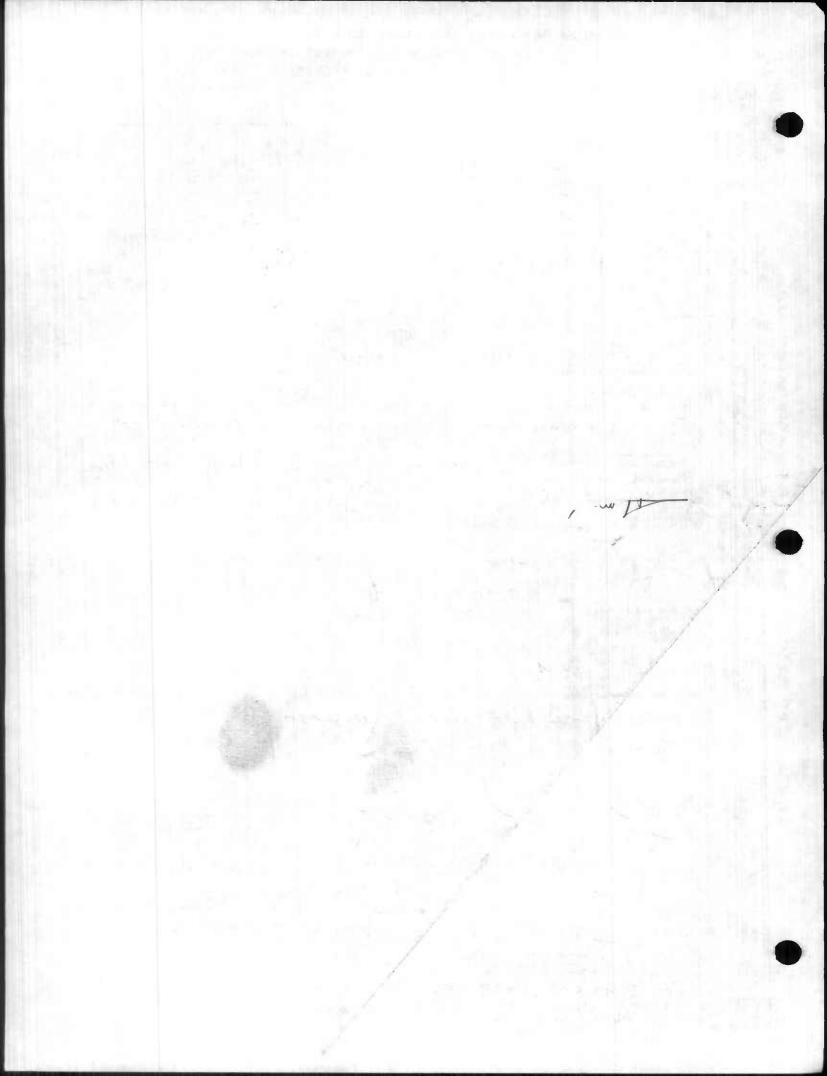
29d. Date signed (Month, Dey, Year)

ALE BALTIMORE MD 21202



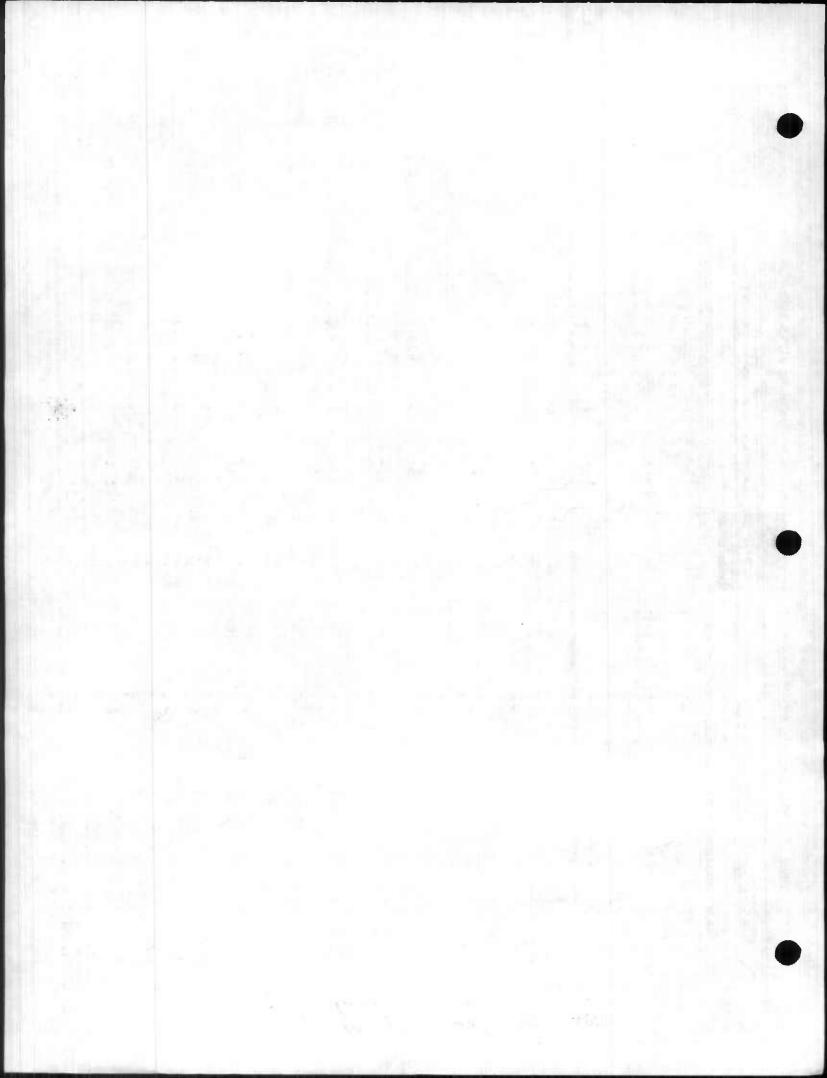
State of Maryland / Department of Health and Mental Hygiene 0 0 24516

				Certi	ficate of	Death	Re	g. No.	- Brown	1010
		1. Decedent's Nama (First, Middla, Las	0				2. Date of Deat	1		3. Tima of Death
	Physician	ROBER	T. L.	Hom	BER	9	AUGU.		Yaar 2000	150 AM
	/Medical Examiner	4a Facility Name (If not institution, giva	street and number)			4b. City, Town, or Le	P . 4 . 4 .	4c. County o		
	Examiner	BON SE	cours 1	HOSPI	TAL	BAL:	TIMORE	N	IA	
	Funeral	5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Yaar	If Under 24 Hrs.	8. Dete of Birth		9. Birthpla	ace (Stata or Foreign
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	or 28a-1 sh be notified a	MD N	A			more				10 765 2 □ No
		10e. Street end Number	UZERNE A	VE	10f. Zip Coda	1324	10	og. Citizan of Wi		y?
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5-0	ed within 72 ho ygiene. er then "natur i, the Medical. Completed	15. Decedent's Edu (Specify only highast grad		16a. Deceden	nt's Usual Occup	pation during most of work	ina	16b. Kind of Bus	inass/Indu	astry
2	mble de	Elementery/Secondery (0-12)	College (1-4or 5+)		_	during most of work d)	9		_	D. T.
2	white and	1245	NIA	5	PANATAI	100		0114	0)	BALTIMORE
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an	am a	19a. Informant's Name/Ralationship (T				and Number or Rus				Coda)
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ć	execution and rial-tran	Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disaase or injury								
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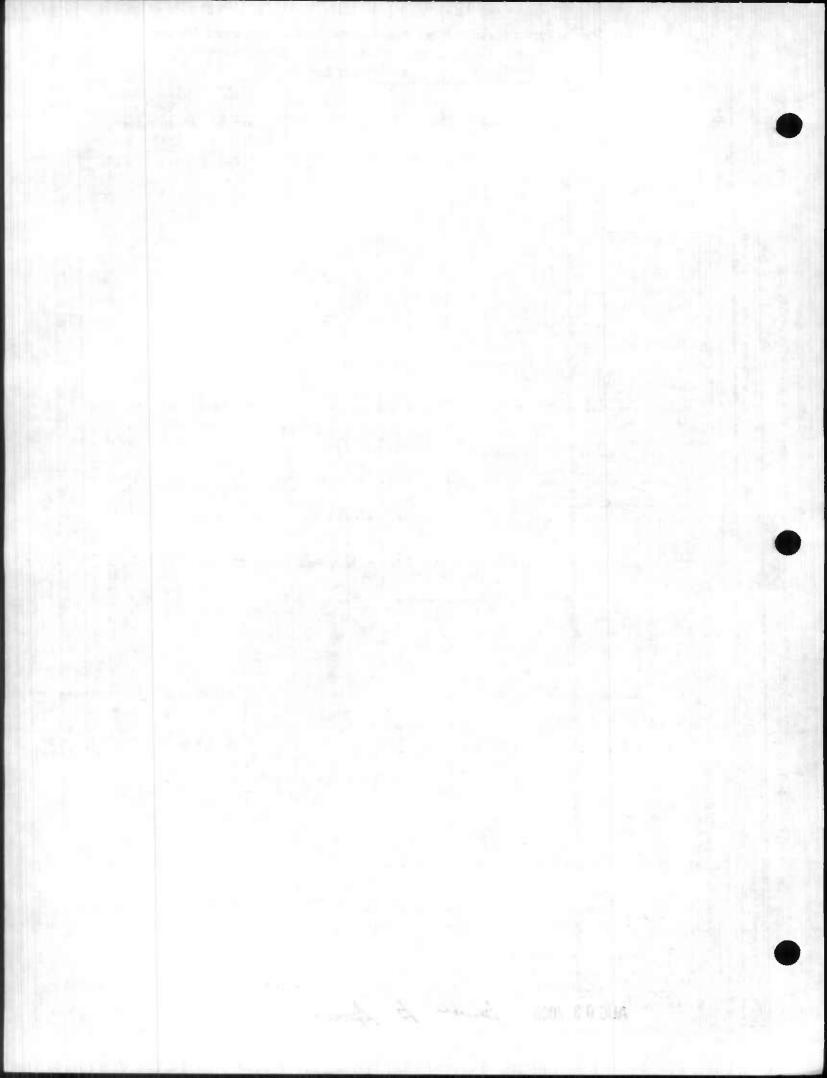
State of Maryland / Department of Health and Mental Hygiene

			Certifi	icate of l	Death	F	leg. No.	U	24517
Physician	Decedent's Name (First, Middle, Last Annie Louise John					2. Date of Dea Month July 3	th 2000	Year	3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give				6b. City, Town, or Li Baltimore	ocation of Death	4c. County		
Funeral Director		7. Age (In yrs.		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 2	, Year)	9. Birthple Count NC	ace (State or Foreig ry)
Maryland -f ahow That at	Usual Residence of Decedent 10a. Stafe 10b. County Md. n/a	10c. Cit	y, Town or Location	altimo:	re			10	od. Inside City Llmif
ath with the Merylar 23s or 28s-f show ust be nothed at rai Director	10e. Street and Number 1719 N. Wolfe Stre	et	10	0f. Zip Code 212	213	1	0g. Citizen of V USA	What Count	ry?
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ed within 72 hours ygiene. er than "natural", 1, m Madical E.	15. Decedent's Edu (Specify only highest grad		16a. Decedent's (Give kind life, DO N		during most of work	ing	16b. Kind of Bu	usiness/Ind	ustry
within 72 hours of giene. In Medical Enem Completed by I	12th Grade	College (1-4or 5+)	Nurses'				John Hop	okins	Hospital
Be fill H	17. Father's Name (First, Middle, Last) John Jones				18. Mother's Nam Annie Te		Ma <i>iden</i> Sumam	10)	
and 2 should and 2 should and 2 should and Mer n. 27 is marken or traumatic	19e. Informant's Name/Reletionship (T) Sylvia Sumpter	Daughter			and Number or Rur t Drive B				Code)
o of the contract of the contr	20a. Method of Disposition 1 XXX irial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	Place of Disposition emetery, cremator odlawn Ce	ry or other plac		Date Aug. 3 W	20c. Location -		
permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Licens		22. Na	me and Addres	ss of Facility Nut	ter Fun	eral Ho	mes,	Inc.
	23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death							Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Metastation	Acons		stic lu	ing Co	urcine	ma	Onset and Death
ertificate be executed ding physician and se as the burist-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	r as a consequenc						
that the death cert ed by the attendin detached for use	Part II. Other significant conditions co		ulting In the underl	lying cause giv	en in Part I.				the cause of death
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00 =						24a. Was a perfor		con	re autopsy findings ilable prior fo npletion of cause leath?
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or Attanding Physician: The street of attanding Physician: The Director, After this centificated in by the funeral director, pare ertification: To Be Co	27. Manner of Death 1. Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Work	y at k? Yes 2 No	28d. Describe h	ence 6 □Oth ow injury occur		,
tal or Attanding P is after death. al Director: After tied in by the funers Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (S City or Tow	treet and Numb n, State)	per or Rural	Route Number,			
Hospi 24 hour Funer tely fill	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinate and manner stated.	wiedge, deeth occ tion and/or investig	curred at the ting gatlon, in my o	ne, dete end plece, pinlon, death occur	and due to the cred at the time, c	ause(s) end ma late and place,	anner as sta and due to	ated. the cause(s)
To the within 2 To the comple	29b. Signature and title of ceptifier	2011		29c. Licens	e number		29d. Dafe signe	d (Month, E	Day, Year)
	· alexenso	gottw)		000	546	+	tuq 3	,20	
5	30. Name and address of serson who co	repleted cause of death (Item	OCUL RA	won F	IW. B	altime	ste, M	D	2[239
State Registrar	31. Date filed (Month, Day, Year)	32. Registrary Signa	ture 4	1					



State of Maryland / Department of Health and Mental Hygiene 00 21,510

				Certific	cate of L	Death		Reg. No.	0	240	10.
21	1-7	1. Decedent's Nama (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of D	Death
	hysician Medical	George Lawrence Kay	lor					3, 2000		12:23	a.m.
	xaminer	4a Facility Name (If not institution, give st	reet end number)				or Location of Death				
14		108 Conestoga Road				iddle R			imore		
	neral ector	5. Social Security Number 6. Sax 185–12–9309	7. Aga (fn yrs. las		Indar 1 Year nths Days	If Under 24 H Hours M	s. B. Date of Bird (Month, Da		9. Birthpl Count Penns	lace (State or i try) sylvani	Foreign La
pue j		10a. State 10b. County	10c. City, 1	Town or Location	n	7			11	0d. Inside City	y Limits
Mary	to fed	Maryland Baltimore	Midd	dle Rive	er					1 ☐ Yas 2	2 01 0
h the	be northed Director	10e. Street and Number		10	of. Zip Code	0-1-0		10g. Citizan of V	Vhat Coun	try?	
th wil	a le	108 Conestoga Road			21220			U.S.A			
21215-0020 do within 72 hours after death with the Maryland glene. withen "centural", or terms 23s or 28s-4 show	Examine must be notified at by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U,S. Armed Forcas? 1 12 Yes 2 □ No If Yes, Give WWII Year or Dates:			ispanic Origin? n, Mexican, Pu Specify:	(Specify Yas or No arto Rican, etc.)	Specify	e - America ck, White, c	etc.	
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or I and of Health Health	othe	20a. Method of Disposition	20b. Plac	ce of Disposition			Date	20c. Location -			
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68760, \tag{41}	s the bunal-transit	Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disaase or injury	Due to (or a	is a consequenc	e of):			1997	1		
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Or Attendate deat	by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicida datarmined	28a. Place of Injury - At hom building, atc. (Specity)	e, farm, street, f		Yes 2 □ No	28f. Location (City or To	Street end Numb wn, Stete)	er or Rure	l Route Numb	ber,
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H 3 F)	* dalmou	Un. In	W	1150	クイス	1	8/03	100)	
10	, 1	30. Name and address of person who com	apleted cause of daath from 2	3a) (Type, Print)	LTI	MOR	E, M	DZ	123	7	Paris I
	State	31. Date filed (Month, Day, Year) 200	32. Registrar's Signatur	a 4	dra	4.					

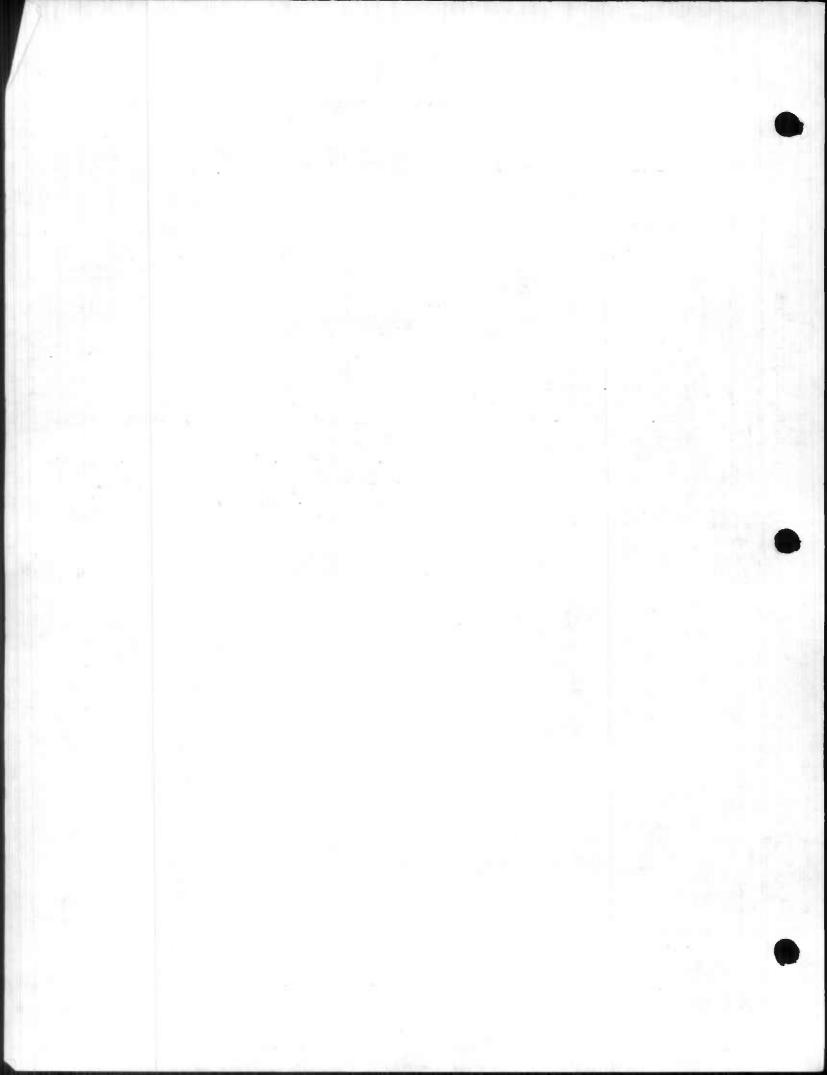


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hysician		Decedent's Neme (First, Middle	Leonar	д т	ames	Kincai	ia	2. Date of Dea Month July	_	2000	3. Time of Deeth	
/Medical xaminer	4.0	Facility Name (If not institution				Rineal	4b. City, Town, or			y of Death		
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neral ector	2	Social Security Number 213-28-7628	6. Sex 1₺ M 2□ F	7. Age (In yrs	. last birtho	Months Days		8. Date of Birth (Month, Da) Oct. 8	, 1932		place (Stete or Foreign ntry) yland	
deal Examiner must be notified at eted by Funeral Director	10	suel Residence of Decedent Da. State 10b. County Maryland B De. Street and Number	altimore	10c. C	ity, Town o	r Location	Dundalk		10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 25 No	
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by Funeral Director		. Merital Status 1 Never Merried 2 Marri 3 Widowed 4 Divorced	12. Was Dece Armed For 1 1 Yes If Yes, Give Year or De	ces? 2 No	rean	13. Wes Decedent of If Yes, specify Cut		pecify Yes or No- o Rican, etc.)		ce - Ameri ick, White, fy:	can Indien,	
pete		15. Decedent (Specify only highes	's Education t grade completed)	14.5111	16a. De	ecedent's Usuel Occu	pation during most of wo	rkina	16b. Kind of B	Business/In	ndustry	
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90		Robert F. Kin						ne (First, Middle, ny Coste		me)		
Ţ		9a. Informent's Name/Reletionsh		Wife)	19b. M	leiling Address (Stree			n Code)			
ner tre		Mrs. Veronica				 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2619 Plainfield Road Dundalk, Maryland 2122 						
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location (Cemetery, cremetory or other place)										own, State	
BOUG			0			22. Name end Addr Duda-Ruck	ess of Fecility Funeral H	Home of I	Dundalk	. Inc		
niner	Im di re	3a. Perti. Enter the disease, or shock, or heart feiture. List of mediate Cause (Finel sease or condition sulting in death)	only one cause on ee	ardial Due to (th. Do not	7922 Wise		ndalk, Ma	aryland	212		
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by Physician/Medical Examiner	Im di re	Ga. Perti. Enter the disease, or shock, or heart feilure. List of the sease or condition suiting in death) equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at intileted events suiting in death) Last	Myoc B. Hypo Agon d	ardial Due to (xia Due to (al Asp Due to (al hour to (al hour to (al hour to (al hour to (al hour to (al hour to (al hour to (al hour to (al hour to (Infa Infa or es a cor or es a cor irati or as a con	7922 Wise enter the mode of dy crction assequence of): On sequence of):	Ave. Dur	23b. Did t	aryland rest,	212 ontribute t 3 Pro 24b. W	Approximate Intervel Between Onset and Death 12-18 hrs II	
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DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)
AUG U 3 ZUUU

Amy M. Dvorcek, DO, 2401 West Belvedere Avenue, Baltimore, MD 21215-5271



		tate of Maryland		ificate of			Reg. No.	loss	101.0
Physician	Decedent's Name (First, Middle, Last) MARV	ARUE	INRE	N7		2. Dete of Dea Month		Year	3. Time of Death
/Medical Examiner	4e Facility Name (If not Institution, give street	et end number)	F-01/F	1	4b. City, Town, or L	ocation of Deeth	4c. County o	f Deeth	
	Catonsville Commons				Catonsvil	.1e	Bal	timor	e
Funeral Director	5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. les 86	st birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, De) Jan 29		9. Birthpled Country Mary1	e (Stete or Foreign and
anyland show	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation				10d	. Inside City Limits 1 ☐ Yes 2 ☑ No
e Me	Maryland Baltimore	To	wson						
ter deeth with the Merylan term 23a or 28a-f show the must be notified at the must be notified at the funeral Director	10e. Street end Number 908 Locustvale Road			10f. Zip Code 212	04		U.S.A.	hat Country	?
020 or, or or, or	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces? I Yes 2 Mo If Yes, Give Yeer or Detes:		as Decedent of H Yes, specify Cube	lispenic Origin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Bleck Specify:	- American , White, etc Whi	
T C F	15. Decedent's Education (Specify only highest grade co	mpleted)	16a. Decede (Give k	ent's Usuel Occup ind of work done O NOT use retired	eation during most of world)	king	16b. Kind of Bus	iness/Indus	stry
d 2121 filed within Hygiene. mther than	Elementery/Secondery (0-12)	College (1-4or 5+)	Seamst			JT 6	Inte	rior	Decorating
	17. Fsther's Neme (First, Middle, Last)				18. Mother's Nem	e (First, Middle,	Maiden Sumeme)	
rylan rould be I Mental be I Mental be I Mental be I merked o metic eve	Albert R. Hogg				Susan E.	Beale			
E SEE	19s. Informent's Neme/Relationship (Type,	Print)	19b. Mailing	Address (Street	end Number or Ru	rel Route Numbe	r, City or Town, S	Stete, Zip C	ode)
2 E E E	John D. Lorenz / ne				Road, Li	nthicum	, Maryla	nd 21	090
S To He	20a. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Specify)	ovel from Stete	netery, creme	ition (Neme of etory or other plean Mem. G		Dete 3/4/2000	20c. Location - C		
ficete be executed ficete be executed for the partition of partition and first burial-transit as the burial-transit as the burial-transit edical Examiner.	23e. Pert1. Enter the disease, or complications, or heart feilure. List only one-of-complications are considered to the complication of the complete considered to the complete considered to the complete considered to the conside	Auli Due to (or a		4107 Will return the mode of dying the mode of dying the mode of t	Funeral	or respiretory er	<u>ltimore,</u> rest,	- I A	Pand 21229 pproximete iterval Between inset end Deeth
is, P.O. Box 6 se that the death certific greed by the attending be detached for use as by Physician Me	Pert II. Other algnificant conditions contrib				ven in Pert I.	1 🗆 '	/ee 2□ No	3 Proba	he cause of dealth? bly 4 Unknown a autopsy findings able prior to
2 × × ×	Du	30 0,1				perio	111001		pletion of cause
The lever page 2						101	'es 2X No	10	Yes 2 No
Vital Vital Intellan: The certificate irector, pag	25. Was case referred to medical examiner?				26. Piece of Dee	th (Check only o	ne)		
- 5 m	1 Yes 2 No Hosp	1 L Inpatient 2 L E	R/Outpatient		4 Nursing H	ome 5 Resid	lence 6 Othe	r (Specify)	
5 5 5 6	27. Menner of Death 1 Neturel 5 Pending	8a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injui Wor		28d. Describe h	low injury occurre	ed	
Division (To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After completaly filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At hom building, etc. (Specify)	ne, ferm, stre		Yes 2 No	28f. Location (S City or Tox	Street end Numbe m, Stele)	or or Rurel I	Route Number,
he Hospital in 24 hours he Funeral pletaly filled		n: To the best of my knowl On the basis of examinetic end manner steton							
To the comple	29b. Signature and title of certifier	~ the	~y)	7 29c. Licens	6942		29d. Date signed	(Month, Di	ey, Year) 2000
	30 Name end address of person who complete the complete t	D 1009, Fr	ed.	rint) Nik Le). Jell	مرسى	2122	28	
State Registrar	31. Dete filed (Month, Day, Year) AUG 0 3 2000	32. Registrer's Signetu	B	Spore	6				

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

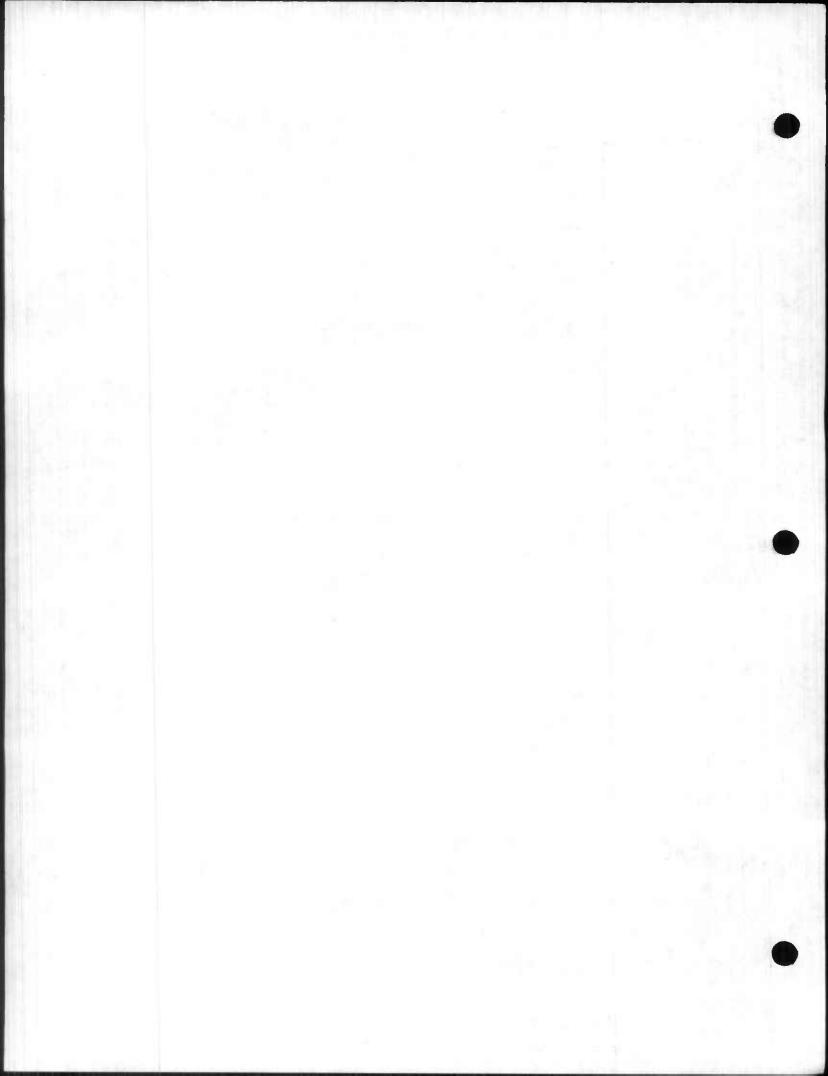
				0.0.0	, , , , , , , , , , , , , , , , , , ,		tificate of	Death		Reg. No.	0 2	24521	
	Physicia	_	1. Decedent's Name (First, Mid						2. Dete of De Month	Day	Yeer	3. Time of Death	
B	/Medic	al	Flora Mae Mus		-1			4b. City, Town, or L	August			11:00 AM	
M	Examin	er	4e Facility Name (If not institut 31 Strawhat F					Owings Mi			imor		
	Funeral Director		5. Social Security Number 228-09-1984		. Age (In yrs. I		if Undar 1 Yaar Months Days	If Under 24 Hrs.		h y, Year)	9. Birtho	elece (State or Foreign try) rginia	
	2	1	Usuet Residence of Decedent 10a, Stata 10b. Coun	itv	10c. City	y, Town or Lo	cation				1	Od. Inside City Limits	
	Maryl 4 sho led a	ō		timore		ngs Mi						1 ☐ Yes 2 ☐ No	
		ă	10e. Street and Number 31 Strawhat F	Road, Apt. 3	BA		10f. Zip Code 21	117		10g. Citizen of W		try?	
020	1 61	by Funeral	11. Merital Status 1 X Never Married 2 Merital Merital 4 Divorce	If Yes Give	es? No		Vas Decedent of I I Yas, specify Cub I ☐ Yes 2 ☑ No	Hispanic Origin? (Speen, Mexicen, Puerto Specify:	pecify Yas or No o Rican, etc.)	14. Race Black Specify.	k, White,	an Indian, atc. ite	
Maryland 21215-0020		Completed	(Specify only high Elemantary/Secondary (0-12	ent's Education hest grade completed)		(Giva life. L	lent's Usual Occu kind of work done DO NOT usa retire	during most of work	16b. Kind of Businass/Industry General Moto				
d 2			1.7. Fathar's Name (First, Middle	e, Last)		C	TELK	18. Mother's Nam	ne (First, Middle,			MOCOLS	
lan		o Be	Monroe Musser	-,,					phine Musser				
ary	F 10 19 W	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass ((Street and Number or Rural Route Number, City or Town, State, Zip Code)					
			Lewis Musser -	- brother				ora Avenue, Baltimore, Md. 21213					
Baltimore,			20a. Method of Disposition 1 Di Burial 2 Di Cremation	n 3 Removal from St	are		sition (Name of natory or other pla		3/02/ ₀₀	20c. Location -			
Ë	thmen tant:		4 Donetion 5 Other	(Specify)	- C		ake Crem	-	027 00	Beltsvi]	lle,	Md.	
Ba	Depa Impo		21. Signature of Furteral Service	feter		Ga 72	50 Washi	nufman Fur	d., Elk	ridge. M	dowri	de MP, Inc. 21075	
			23a Fair Enter the diseasa,	or complications that ceu ist only one cause on eac	used tha death ch line.	n. Do not ente	er the mode of dy	ing, such es cerdiac	or respiretory as	rrest,		Approximete Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Fine)	(ARD	IAC.	ARR	トサイナ	LAL LA			Oliser and Death	
	Examiner		disease or condition resulting in death)	a		r as a conseq		7 ()	THE THE		1		
	D .E	ner											
	icate be executed physician end s the bunal-transit	Examiner	Sequentially list conditions,	6.	Due to (or	r es a conseq	uanca of):						
68760,			Sequentially list conditions, if any, leeding to immediata ceuse. Enter Underlying Cause (Disease or Injury	c									
687		edical	that initiated events resulting in death) Lest		Dua to (or	as a consequ	uanca of):						
Вох	attending for use a	2		d									
	death cert ne attendin ed for use	Sicia	Part II. Other significant condi	tions contributing to deal	th but not resu	ulting in the ur	nderlying ceuse gi	iven in Part I.	23b. Did	tobacco uae cor	ntributs to	the cause of death?	
s, P.O.	P 9 0	by Physician/M	AMIO DA		Lui	va -	Toxic	174	10	Yes 213 No	3 Pro	bably 4 Unknown	
of Vital Record	law requires as been sign s 2 should be	Completed	- 0	ноша					24e. Was perfo	an autopsy med?	av	ere autopsy tindings allable prior to mpletion of cause death?	
<u> </u>	ysician: The lav is certificate has director, page 2	E	Adeni	ocarcin	oma	Li	ung		10	Yes 2 No	1 (☐Yes 2☐ No	
Vita	clan: entific ector,	Be	25. Was cese raferred to media examiner?					26. Piece of Des	ith (Check only o	one)			
of	this eld	Other: 4 Nursing Ho								dence 6 Other		y)	
Division	Attending or deeth.	27. Manner of Death 1 Natural 5 Pending 2 Accident 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Accident 28c. Injury at Work? 1 Yes 2 No											
DİVİ	To the Hospital or Attending Phywitin 24 hours after deeth. To the Funeral Director: After thi	3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)							281. Location (S City or Tox	Street and Numb vn, Stata)	er or Rura	il Routa Number,	
	To the Hospital within 24 hours To the Funeral completely filled	edicai	29a. Cartifiar 1 Certify (Check only one)	ring Physician: To the best at Examiner: On the basi end manne	ia of examinet	wledge, daath tion and/or inv	occurred at tha ti restigation, in my	ime, data and place opinion, daath occu	, and dua to tha rred et tha time,	causa(s) and ma data end piace, a	nnar as s and due to	tated. the ceuse(s)	
	o the		29b. Signatura end titla of certif	fier			29c. Licen	se number		29d. Dete signed			
	1		D. She	ruenddei	u MI	2	02	0252		8/0	2/0	0	
(B		30. Nama and addrass of person	on who completed ceusa	of death (Itam		Print)	DS DR	L ou	INGS			
	Stat Registra	е	31. Dete filed (Month Pay2)	10 parents	istrer's Signe								

A "1 . HOME A DENNA

State of Maryland / Department of Health and Mental Hygiene

Physician			(Certificate of	Death		Reg. No.		522			
	Decedent's Name (First, Midd	fle, Last)				2. Data of De Month	ath Day	Year 3. Ti	ma of Death			
/Medical	SARAH =	J. MAI	HAN			AUG	-	2000	1930			
Examiner	4a Facility Nama (If not institution	on, giva street and numb	er)		4b. City, Town, or Loc	cation of Death	4c. County	of Death				
	Howard County	General Hos	pital		Columbia		Howa:	rd				
uneral	5. Social Security Number	6. Sex 7.	Age (In yrs. last birth	day) If Under 1 Year	If Undar 24 Hrs.	8. Date of Birl	h Vees	9. Birthplaca (S Country)	itate or Foreig			
rector	244-20-5830 Usual Residence of Decedent	1□ M 2√ F	80 Y	s. Months Days	Hours Min.	(Month, Da April 1	5,1920	North (
thow a	10a. Stata 10b. County	у	10c. City, Town	or Location					ide City Limits			
Pe notified Director	MD Howa	rd	Glenwo	boo				1	Yes ZX No			
i e	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?				
	3101 Longfield	Road		21738			USA					
E 6	11. Marital Status	12. Was Decede	ent Ever in U,S.	13. Was Dacedant of H	lispanic Origin? (Spe	cify Yes or No	14. Race	- American Indi	an,			
al, or thems 23s of 25s-1 show the must be notified at by Funeral Director	1 Nevar Married 2 Mar 3 Widowed 4 Divorce	If Yes, Give	EXNo	If Yas, specify Cubs	an, Mexican, Puerto F Specify:	Rican, etc.)	Specify:	k, White, etc. : White				
n, the Medical Ex-		ent's Education ast grada completed)	(Decedent's Usual Occup Give kind of work done	during most of working	na	16b. Kind of Bu	siness/Industry				
100	Elementary/Secondary (0-12)		or 5+)	ife. DO NOT use retired	d)							
LO LO	12	Ø		Nurses' Aid			Healt	h				
event, Be Co	17. Fathar's Name (First, Middle), Last)			18. Mother's Name	(First, Middle,	Maiden Sumam	ө)				
To B	Richard Farrel	.1			Elizab	zabeth (Unavailable)						
traumet	19a. Informant's Name/Relation	iship (Type, Print)	19b. I	Mailing Address (Street								
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Deborah Mahan Hock/Daughter 3101 Longfield Rd., Glenwood, MD 21738											
Department of Heelih and Important: If fem 27 is many injury or other traum pince.	20a. Method of Disposition	nock/ Daught		Disposition (Name of	d Rd., GI	Date		City or Town, Sta	ata			
	1 ⊠ Burial 2 ☐ Cremation	3 ARamoval from St	ate cemetery,	crematory or other place								
	4 Donation 5 Other (Specify)	St. Mi	chael's Cem		7/00	Penn Ya					
any In	21. Signature of Funeral Service	Licensee A	MU0741	22. Name and Addra 5555 Twin								
	Standa o	X demme	~				•	-				
	23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause on each	sed the death. Do no h lina.	t enter the mode of dyir	ig, such as cardiac of	r respiratory a	rrest,	Interv	ximate al Between			
cian								Onsei	and Death			
dical	Immediate Cause (Final disease or condition	SMI	HYSEN	1A				5	YRS			
iner	resulting in death)	а	Due to (or as a co									
ē												
the buriel-transit		b	Due to (or as a co	possesses of:								
EXB	Sequentially list conditions, if any, leading to immediate		Due 10 (01 as a 00	risequerica ory.								
	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
	resulting in death) Last		Due to (or as a co	nsequence of):								
Me .		d						1				
lan,												
siclan	Part II. Other significant conditi	ions contributing to deat	h but not resulting in t	he undarlying cause giv	ren in Part 1.	23b. Dld	tobacco usa con	ntribute to the c	nuse of death			
hysician			h but not resulting in t	he undarlying cause giv	ren in Part I.	23b. Did	,	atribute to the care of the ca				
e detached for use as the but y Physician/Medical	Part II. Other significant conditions and the PNS UMON		h but not resulting in t	he undarlying cause giv	ven in Part I.		,					
			h but not resulting in t	he undarlying cause giv	ven in Part I.	1 X	Yes 2□ No an autopsy	3 Probably 24b. Were aut	4 Unknow			
			h but not resulting in t	he undarlying cause gh	ren in Part I.	1 X	Yes 2□No	3 Probably 24b. Were aut available complatic	4 Unknown			
			h but not resulting in t	he undarlying cause giv	ren in Part I.	1 X	Yes 2 No an autopsy	3 Probably 24b. Were aut available complatic of death?	4 Unknown			
pieted by			h but not resulting in t	he underlying cause giv	ven in Part I.	1 X	Yes 2 No an autopsy	3 Probably 24b. Were aut available complatic	4 Unknoopsy findings opsy findings prior to on of causa			
e Completed by	PNS UMON 25. Was case referred to medical	(A	h but not resulting in t		26. Place of Death	24a. Was perfo	Yes 2□ No an autopsy med? Yes 2 No	3 Probably 24b. Were aut available complatic of death?	4 Unknoopsy findings opsy findings prior to on of causa			
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ORIGINAL

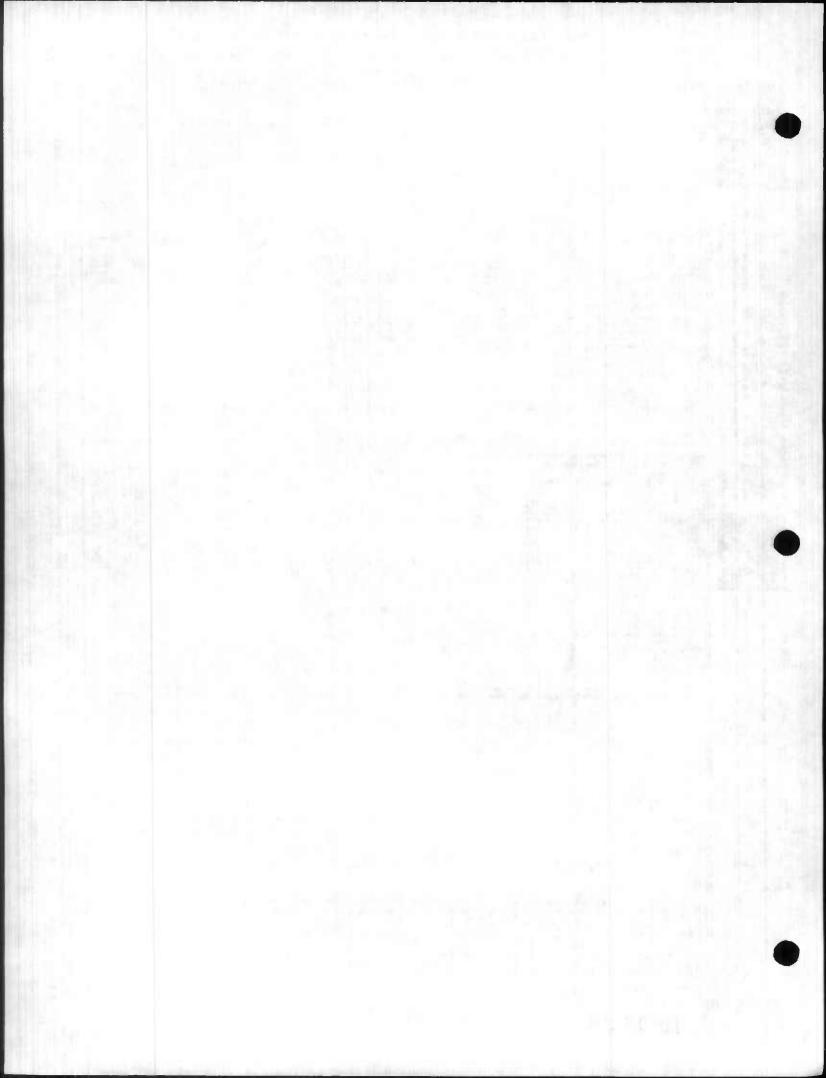


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** July Kenneth Leslie McIntosh 2000 6:45PM /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 907 Radcliffe Road Towson Baltimore If Under 1 Year | if Under 24 Hrs. 8. Date of Birth May 21 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplaca (Stete or Foreign Funeral Days Hours 1907 10 M 2 F Pennsylvania 150-03-8772 93 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f short 1 ☐ Yes 2 ☑ No Md. Baltimore Directo Towson the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nerne 23s or 907 Radcliffe Road 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WWII Specify: White b 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Army & Airforce Elementery/Secondary (0-12) College (1-4or 5+) Budget Analyst Exchange Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Merital reportant: If them 27 is marked o George R. McIntosh Eva Lynn Chaffee 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Helen R. McIntosh/Wife 907 Radcliffe Rd. Towson, Md. 21204 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dale 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Gdns 8-5-00 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenti 22. Name and Address of Facility Towson Funeral Home, Inc. York Rd. Towson, Md. 21204 Ruck 1050 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician immediate Cause (Final disease or condition resulting in death) /Medical A/2 harnier's 710 Examiner Due to (or as a consequenca of) Physician/Medical Examine The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760, Due to (or as a consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 6 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Depeleo by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy SIP TAK performed? page 1 Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Desidenca 6 Other (Specify) 9 1 Yes 2 No this 28c. fnjury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending deeth. Investigation 1 Yes 2 No 2 Accident within 24 hours after deeth To the Funeral Director; completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) A Henry Physica. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 1/1 LUTHERUIUSE, MM) ZIUST 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WILLIAM E. RANDALENL MD, # 33, 1205 YURK RD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Ray 6/95

AUG 0 3 2000

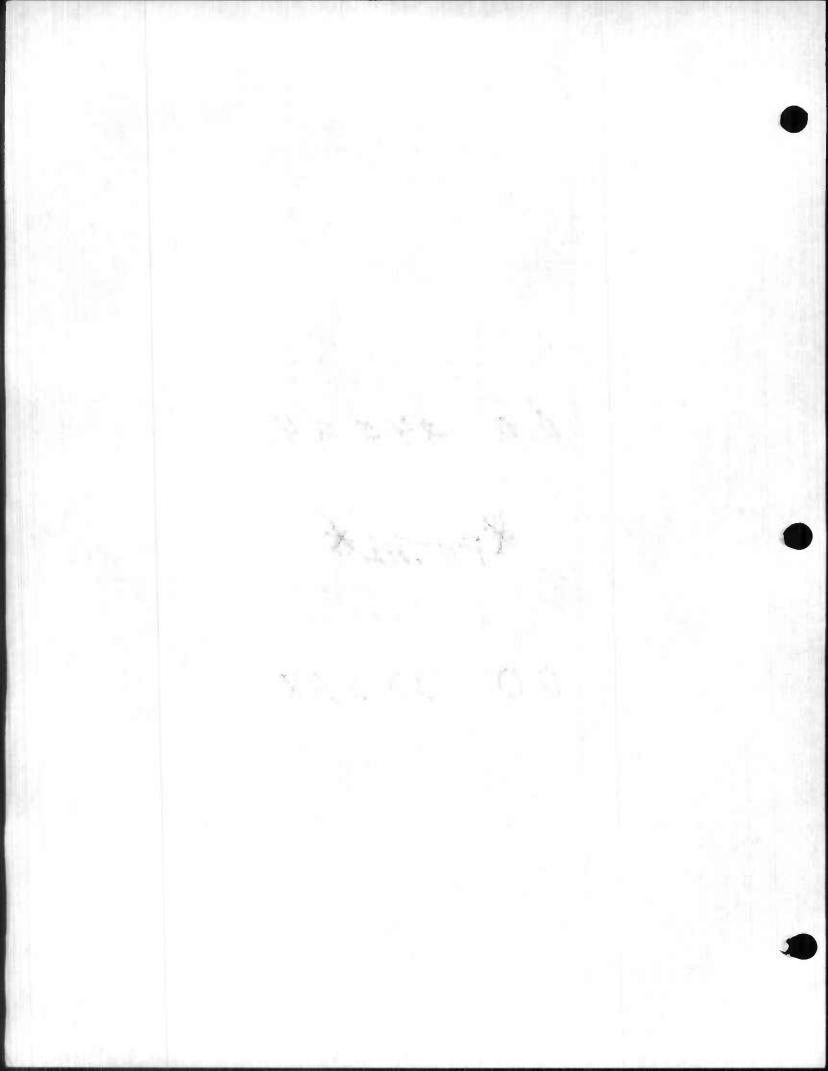


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VOID
CERTIFICATE #

20_24524

SEE *FETAL* CERTIFICATE \$10 00_00668



	State of Maryland / Department of Healt Certificate of Dea		R	eg. No.					
ın	1. Decedent's Name (First, Middle, Last) Beatrice J. Neff		2. Date of Deal Month	Day	Year	3. Time of Death			
al		. Town or Lo	JUL ocation of Death	Y 31,	2000	01:40 PM			
	Saint Joseph Medical Center	Tows		4c. Count		imore			
	5. Social Security Number 6. Sex 1 Months Days Hou 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	nder 24 Hrs. urs Min.	8. Date of Birth June 16	, Year 923	9. Birthp	elace (State or Foreign nitry)			
	Usual Residence of Decedent								
	10a. State				,	0d. Inside City Limits XXYes 2□ No			
	10e. Street and Number 10f. Zip Code		1	0g. Citizen of	What Cour	ntry?			
	6003 Eastern Parkway 21206			U.	S.A.				
1	1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Navar Married 2. Married 1. Yas 2. No If Yes, Give Yaar or Datas: 13. Was Decedant of Hispanic If Yes, specify Cuban, Mex 1. Yas 2. No 1. Yes 2. No Specify Cuban, Mex 1. Ye		ecify Yas or No- Rican, etc.)		ce - Americ ick, Whita, fy: Wh				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during or life. DO NOT use retired) Account Clerk	most of worki	ing	Accou					
17	7. Fathar's Name (First, Middla, Last) Joseph Burda 18. M. An	Maiden Suma	m <i>ø)</i>						
	19a. Informant's Name/Relationship (Type, Print) Charles J. Neff 19b. Malling Address (Street and Nu 509 Cesky Place	land 2	, State, Zip 1014	Code)					
	-City or To	own, State Maryland							
	Inc. land	21206							
	23a. Part 1 Error the disease of court of ations that caused the death. Do not enter the mode of dying, such shock, or heart failure. List out one cause on each line. Immediate Cause (Final disease or condition	h as cardiac c	or raspiratory arr	est,		Approximate Interval Between Onset and Death			
	Due to (or as a consequence of): VANCOMYCIN RESISTANT ENT	rerocc	OCCAL S	EPSIS		2 DAYS			
1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): FRO LYMPHOCYTIC LEUKEMIA Due to (or as a consequence of):	4				4 YEARS			
	d								
F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P SPLENECTOMY	Part I.	23b. Did to			o the causs of death? bably 4 Unknown			
			24a. Was a perfor		av	ere autopsy findings altable prior to impletion of cause death?			
			1 🗆 Y	es 20 No	16	Yes 20 No			
	examiner?	Place of Death	h (Check only or	ne)					
-			me 5 Residence			(y)			
	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2			on anyary cool					
	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	of be 28e. Place of Injury - At home, farm, street, factory, offica 28f. Location (Street and Number or Rural Route Number,							
	29a. Cartifiar (Check only and Examinar: On the basis of examination and/or investigation, in my opinion, and manner stated.								
	29b. Signature and title of certifier 29c. License numb D36814	ber	2	e9d. Date sign	6d (Month.	Day, Year)			
-	30. Nama and address of person who completed cause of death (11 m) 23a) (Type, Print) RICHARD L HUSLIG, M.D., 601 OSLER DRIVE	TOUS	SON MO	RYI ON	D 21	204			
	31. Date filed (Month, Day, Year) 32. Registrar's Signature	. 1	- midd 1.1L	11111111111	a./ L. J.	tus 45° T			

DHMH 16 Ray 6/95

Registrar

AUCOS ESTO James A Cont

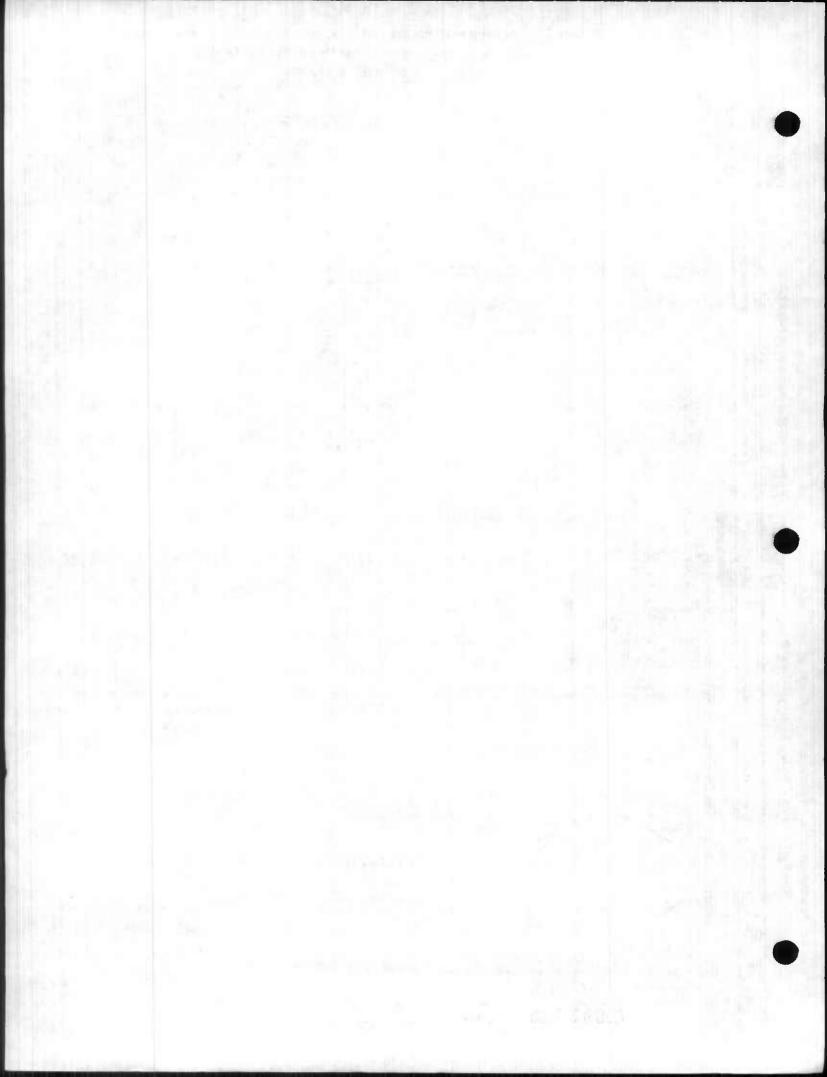
State of Maryland / Department of Health and Mental Hygiene 0 0 24526

Physician	1. Decedent's Nama (First, Middla, La	ast)	1499				2. Data of Dea	eg. No. Ih Dav	Yaar	3. Tima c	f Death
/Medical	Susie	Pate					Ju1y		2000	12:3	7 P.M
Examiner	4a Facility Nama (If not institution, gir	The second second			4b	o. City, Town, or Lo		4c. County	of Death		
	4202 Belle Gro			If Under 1 Y	(1.1.1	Baltimo			e Ar		
Funeral Director		Sax 7. Aga 1□M 2X F	86 Yrs.		ays	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day) Nov. 25	Year) , 1913	9. Birthpi Count Sout	leca (Stata try) :h Car	or Foraign
t u	10a. State 10b. County		10c. City, Town or	Location					10	Od. fnsida C	ity Limits
fied for	Maryland Anne Ar	undel	Baltimo	re						1 🗆 Yas	2X No
be notified	10e. Street and Number			10f. Zip Co	da		1	0g. Citizan of V	Vhat Coun	try?	
	4202 Belle Grove	e Road		21	.225	5		U.S	•		
at, or hans 23s examiner must by Funeral	11. Maritaf Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedant E Armed Forces? 1 Yas 2 N If Yes, Giva Yaar or Datas:		3. Was Decedent If Yas, specify 1 Yas 2 🛭		spanic Origin? (Span, Maxican, Puarto Specify:	ecify Yas or No- Rican, atc.)	14. Race Blace Specify	e - Amarica k, Whita, a Wh	an Indian, atc.	
ical i	15. Decedent's E	ducetion	16a. De	cedant's Usual O	ccupa	tion uring most of works		16b. Kind of Bu	sinass/Inc	lustry	
ygions. Nor than "natural. A. the Medical. Completed	(Specify only highast grant Elementary/Secondary (0-12)	College (1-4or 5	+)	i. DO NOT usa r	atired)	uring most of work	ng				
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To		Henry Power									
if of Health and If Hem 27 is in or other traum	19a. Informant's Name/Ralationship	(Type, Print) Daughter				nd Number or Run ove Road		imore,			21225
	20a. Mathod of Disposition	Daugitter						20c. Location -			.1227
taint of taint of taint of taint of o	1 XBurial 2 Cramation 3 4 Donetion 5 Other (Speci	fy)	20b. Place of Discematery, of Glen Ha	ven Memo	oria	al Park 8		Glen Bu	,		land
Depar Impor	23a. Part1. Enter the disease, or conshock, or heart failure. List only	mme	The hand		chi	le H i ghwa	_	imore,			
Medical xaminer	Immediata Causa (Final disaasa or condition resulting in death)	a. As	bua to (or as a cons	aquenca of):	un	ienta	2,21		C	onem	mth
burial-transit	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events	b	Dua to (or as a cons	sequence of):				5.4			
phys as the edic	Cause (Disease or injury that initiated events rasulting in death) Last		Dua to (or as a cons	sequance of):					-		
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hes been signed e 2 should be de mpleted by	recent small	1 Intesta	alosit		- a	dhesi'on	24a. Was a perfor	mad?	ave	ara autopsy ailable prior mplation of death?	
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AUG 1.2 2000

State of Maryland / Department of Health and Mental Hygiene 00 24527

			Cei	rtificat	e of	Death			Reg. No.	U 1	.7061
	1. Decedent's Name (First, Middle, La.	st)						2. Date of De		Vons	3. Time of Death
Physician (Modisol	Charlotte	A. R	iddle					August	Day	2000	7:50Ai-l
/Medical Examiner	4a Facility Neme (If not institution, give	e street and number)				4b. City, To	wn, or Lo	ocation of Deeth	4c. Cour	nty of Deeth	
	Genesis Elde	er Care				Sever	na F	Park	Anne	Arun	del
Funeral	5. Social Security Number 6. S		last birthday)	If Under Months		If Under		8. Dete of Birt	th Veerl	9. Birth	place (State or Foreign
Director	220-07-8359 Usual Residence of Decedent	□M 280F 86	Yrs.	Months	Days	Hours	Min.	Feb 28	1914	Ma	Tyland
No N	10a. State 10b. County	10c, Ci	ty, Town or Lo	ocation						1	Od. Inside City Limits
or 28a-4 st be notified Director	Maryland Anne Art	undel Pa	sadena	10f. Zip	Code				10g. Citizen o	d What Cou	1 Yes 2 No
	7673 2nd Street	et		101. 210	211	22			USA	r what cour	wy r
at, or flere 23 Examiner must by Furneral	11. Merital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deced If Yes, spec		lispanic Ori an, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	Spec	ace · Americ lack, White, bify:	
ygiene. we than 'natur t, the Medical Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usue kind of wo	ol Occup	ation during mos	t of work	ing	16b. Kind of	Business/In	dustry
and de	Elementary/Secondery (0-12)	College (1-4or 5+)	tife.						To	lepho	no
C HA	12			Ope	rau		de Alexa	- /Final Middle			iie
Mental H srked of sric ever To Be	17. Father's Name (First, Middle, Last) Charles A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street en						other's Neme (First, Middle, Maiden Sumeme) therine Muhler				
eath and n 27 is ma ser treum	19a. Informant's Name/Relationship (Janet E. Henderso	Type, Print) n daughter	19b. Mailii 7673	ng Address 2nd S	tree	end Number	ader	na, MD 2	er, City or Tow 21122	m, Stete, Ziţ	Code)
ent of He nt: If Nem ry or othe	20a. Method of Disposition tV□ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specific	Removal from State	Place of Disponentery, cremetery, cremetery	metory or o	ther pla		8,	Date /4/2000	Glen B		, Maryland
Departiments and injury injury and and and and and and and and and and	21. Signeture of Funeral Survey Libert 23a. Part1. Enter the disease, or comshock, or heart failure. List only)		Stal 3111	ling	untair	iera 1 Roa	Home I	dena. M	1D 211	Approximate
nysician Medical	shock, or heart failure. List only tmmediate Cause (Final	0									Interval Between Onset and Death
xaminer	disease or condition resulting in death)	a. ARTERIO	sec	ERD	710		1/2/	110 V/7	seur	2	2 WEEK
Je Je		Due to (or as a consec	quence of):					VISEA	36	
n and ial-transit	Sequentially list conditions, if any, leading to immediate	b. Due to (Due to (or as a consequence of):								
ing physicia a as the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	C Due to (d	or es e conseq	quence of):							
d for use	Part II. Other significant conditions o	patributing to death but not re-	culting in the u	inderlying c	euce ci	en in Part I		23h Did	tobacco use i	contribute (o the cause of death
ed by the attend detached for us	Part II. Other significant continuous C	orthoding to death but not re-	solling in the o	indenying c	ause yn	on mraiti	•				bably 4 thinknow
page 2 should be det									an autopsy ormed?	6/	fere autopsy findings vailable prior to ompletion of cause death?
page page								10	Yes 24H	1	☐ Yes 2☐ No
certificate rector, pag	25. Was case referred to medical				1/1.	26. Place	of Deal	th (Check only	one)		
this ald	examiner? 1 Yes 2 No 27. Menner of Death		ER/Outpaties)A		ursing Ho	ome 5 Resi			fy)
octor: After by the fune lfication	1 Netural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Dey Year)	Injury	М	8c. Inju Wo 1 □	rk? Yes 2□	No				
within 24 hours after death. To the Funeral Director: After toompletsiy filled in by the funer completely filled in by the funer. Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, factor	, office			28f. Location (City or To		mber or Rur	al Route Number,
within 24 hours To the Funeral completely filled		ysician: To the best of my known ther: On the basis of examination and manner steted.									
ro the	29b. Signalate and title of certifier	Ne selection is		290	. Licens	se number			29d. Date sig	ned (Month,	Dey, Year)
O,	1 Anu	4 Mg			21	776)		AUGUS	7 2	2000
SKY	30. Name and address of person who		m 23a) (Type, 3001	Print) S-H	A	WVG	2 3	T BA	ctim	one	21225
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign			Con	60					



State of Maryland / Department of Health and Mental Hygiene

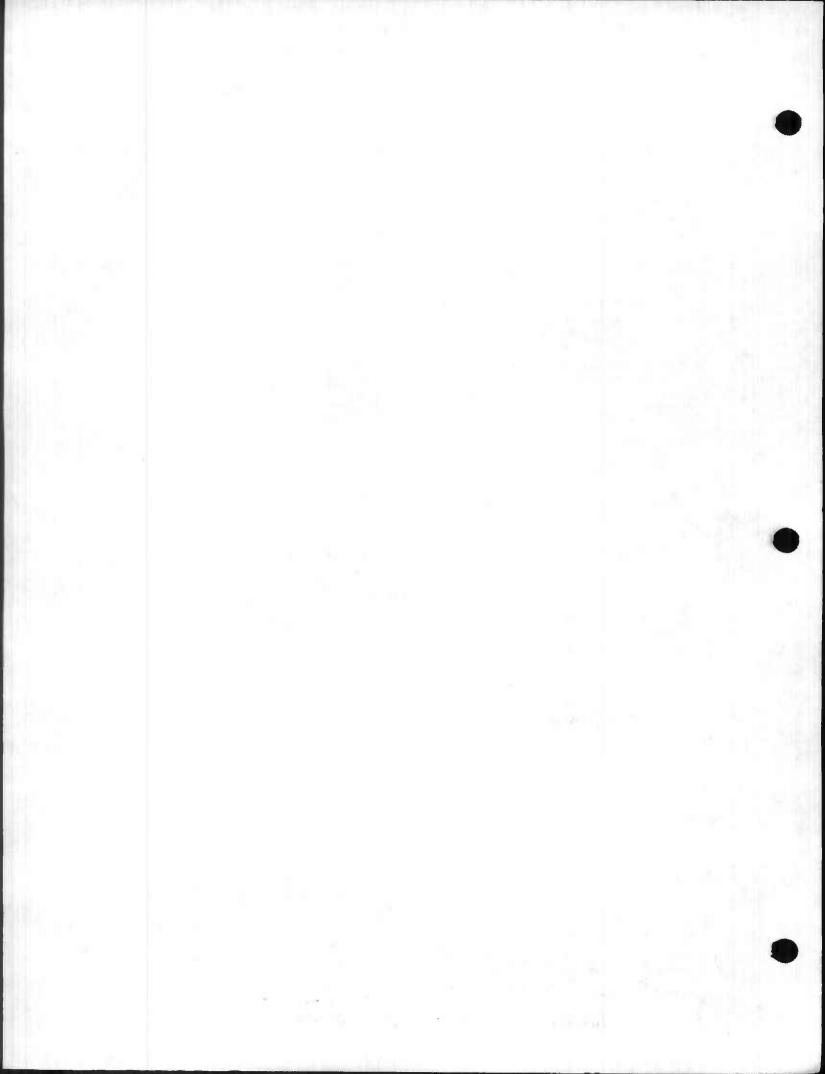
				C	ertificate of	Death	R	eg. No.	24528
	hysician /Medical	1. Decedent's Name (First, Middle, L		Rein	ISNIBEN		2. Date of Deat Month	Day O/ Zi	3. Time of Death
Fu	xaminer		g Home	(In yrs. last birthd		4b. City, Town, or Lo Columbia If Undar 24 Hrs. Hours Min.		4c. County of HOW (1997), 1903	ard
2	ector	Usual Rasidence of Decedant	AA			+	ec. 19	7, 1903	
Maryla	be notified at Director	MD Howar	ď	10c. City, Town o					10d. Inside City Limits 1 ☐ Yas 2 ☐ No
h with the	ust be notified	10e. Street and Number 6334 Cedar Lar	ıe		10f. Zip Coda 2104	4	1	0g. Citizan of Wh USA	
har dea	Evantiner in by Funer	11. Marital Status 1 Nevar Married 2 Married 3 Millioned 4 Divorced	12. Was Decedent B Armed Forcas? 1 Yas 2 XN If Yas, Give Yaar or Datas:	var in U,S.	13. Was Decedent of If Yas, specify Cul 1 ☐ Yas 2 ☒ No	Hispanic Origin? (Spe ban, Mexican, Puarto I Specify:	cify Yes or No- Rican, atc.)	Black,	American Indian, Whita, atc. White
21215-0020 within 72 hours at piene.	t, the Medical	15. Decedent's E (Specify only highast g	ducation ada complatad)	16a. De	ecedent's Usual Occu	ipation a during most of working ad)	ng	16b. Kind of Busi	inass/Industry
212 d within	dimo.	Elementary/Secondary (0-12)	College (1-4or 5	+)	omemaker	50)		Own	Home
and the file	Be as					18. Mother's Name		Aaidan Sumema,	
Maryl od 2 should	1 and 2 should Health and Men wm 27 is marks other traumatic	17. Father's Nama (First, Middle, Last)					l Routa Number		tete, Zip Code) 44303
more,	ry or other	20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 35 Other (Spec		cematery.	isposition (Nama of crematory or other plants of the ridge Me	m. Park	B/05/00		ity or Town, Stata cridge, Md.
Balti pemit. Departm	any inju	21. Signature of Funeral Service Light	to			Kaufman 1			@ Meadowride
Physi /Med	dical	23a. Part / Entar the disease, or cor back, or heart failure. List only Immediate Cause (Final disease or condition resulting in deeth)					r respiratory arra	ast,	Approximata Interval Between Onsat and Death
	i i	Tooling in destiny	He set	Dua to (or as a cor	A JAILLY (nsequence of):				0
68760, ifficete be assecuted	s the burial-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last	c	Oue to (or as a con	sequance of):				- Gus
	D 80	Tasuning III obadily East	d		***************************************				
) i	ached	Part II. Other significant conditions	contributing to death bu	t not rasulting in th	na underlying causa g	ivan in Part I.			ribute to the cause of death?
requires	should be d	Dewentin					24a. Was a perform		24b. Wara autopsy findings available prior to completion of causa of death?
The lew	page 2						1 🗆 Ye	s 2 Avo	1 Yas 2 No
Or Vital P Physician: The		25. Was case rafarred to medical examinar?	Hospitel:	• • • • • • • • • • • • • • • • • • • •		26. Placa of Death			10 11
Attending Physic death.	tion: To	1 Yas 2 No 27. Mannar of Death 1 Dylaturel 5 Panding 2 Accident investigation	28a. Data of Injur (Month, Day	y 28b. Tim	a of 28c. toj	AND Nursing Hor		nce 6 Other	
DIVISION al or Attending s after death.	Certification:	3 Suicide 6 Could not 4 Homicide determined		1	28f. Location (SI City or Town	raat and Number n, Stete)	r or Rural Roula Number,		
To the Hospital or Attending Phywithin 24 hours after death.	pletely fille		hysician: To the best of miner: On the basis of and manner sta	axamination and/o					
To the within	N N	29b. Signature and title of certifier			29c. Licer	nsa number	2	9d. Date signed	(Month, Day, Year)
	10	X Confree			0	-3486	8	Aley O	5,2000
2	DR	30. Nama and address of person who	11055	L Hills	PAfruit	PIL Colu	what i	MV) Z	iny
R	State egistrar	AUG 0 3 2000	32. Registra	's Signarte	spals				

2000 June 15 Junes

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State of Maryland / Department of Health and Mental Hygiene

					Cer	titicate	e of	Death			Reg. No.	0 6	40	23
	1. Decedent's Name									2. Date of De Month	ath Day	Year	3. Time o	f Death
an al	Kathy Ce	leste R	iddick							July	30		09:25	5 A.1
r	4a Fecility Name (If n						- 1			cation of Deat		1000		
			Hospital			If Under	1 Vear	Rar		stown		ltimor		
	5. Sociel Security Nun 217-70-162	27	1 M 2 □ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Age (In yrs. lest	Yrs.	Months	Days	Hours	Min.	(Month, De	7, 1957	9. Birthpla Countr	y)	or Foreig
	Usuet Residence of D 10a. State	10b. County		10c. City, To	own or Loc	ation	-					10	d. Inside (City Limit
	Md.		timore		Woo	dlaw								2 N
	10e. Street end Numb		ive Apt.	F		10f. Zip	Code				10g. Citizen of USA	What Countr	y?	
	11. Merital Stetus 1 Never Merried 3 Widowed 4		12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	ss?		/as Deced Yes, spec		lispanic Ori en, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	14. Rai Bta Specif	ce - America ck, White, et y: Bla	c.	
	1 (Specify	5. Decedent's E	ducation rade completed)	1	6a. Decede	ent's Usua	l Occup	ation during mos	t of work	ing	16b. Kind of B	Jusiness/Indu	istry	
	12th Grad	dary (0-12) de	College (1-4	or 5+)	ecept:			1/			Telespe	ectrum		
	17. Father's Neme (Fi		1)							e (First, Middle e Riddi	Maiden Sumer LCK	ne)		
	19a. informant's Nem Andrew R.		(Type, Print)	on 1	9b. Mailing 4407	Address Norfo	(Street	end Numbe Avenu	er or Rure le Ba	A Route Numb	er, City or Town	21216	Code)	
1000		Cremation 3	Removet from St	ete came	of Dispos etery, crem	etory or of	her ple		A	Date ug. 4	20c. Location Woodlaw			-
	21. Signature of Fune			Po	22.	Name and	d Addre	ss of Fecili	y Nut	ter Fur	neral Holtimore			5
-	23a. Part1. Enter the shock, or heart	disease, or con	nplications that cau	sed the death. [_					107	Approxima	te
cal Examiner	disease or condition resulting in death) Sequentially list cond	ditions,	b. DEE	Due to (or as	a consequence of consequence	penca of):	LVI	CVE	IN .	THRUM	BOSIS			
3	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las		C	Due to (or as	a consequ	ence of)				_				
	resulting in death) La	st	d				ause div	en in Part		23b. Did	tobacco use co	ontribute to	the cause	of death
	resulting in death) La:	ant conditions	contributing to deat				ause giv	en in Part	l.		tobacco use co Yes 2□ No			
	resulting in death) La:	st	contributing to deat				ause giv	en in Part		1 🗆		3 Probe		findings to
	resulting in death) La:	ant conditions	contributing to deat				ause giv	en in Part		1 🗆 24a. Was perfo	Yes 2□ No an autopsy	3 Probe	re autopsy lable prior pletion of eath?	findings to
in a second seco	resulting in death) La: Part II. Other signification in the signification in the signification in the signification in the signification in the signification in the significant in the	ant conditions of	contributing to deat				ause giv			1 🗆 24a. Was perfo	Yes 2 No Yes 2 No	3 Probe	re autopsy lable prior pletion of eath?	findings to cause
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State of Maryland / Department of Health and Mental Hygiene

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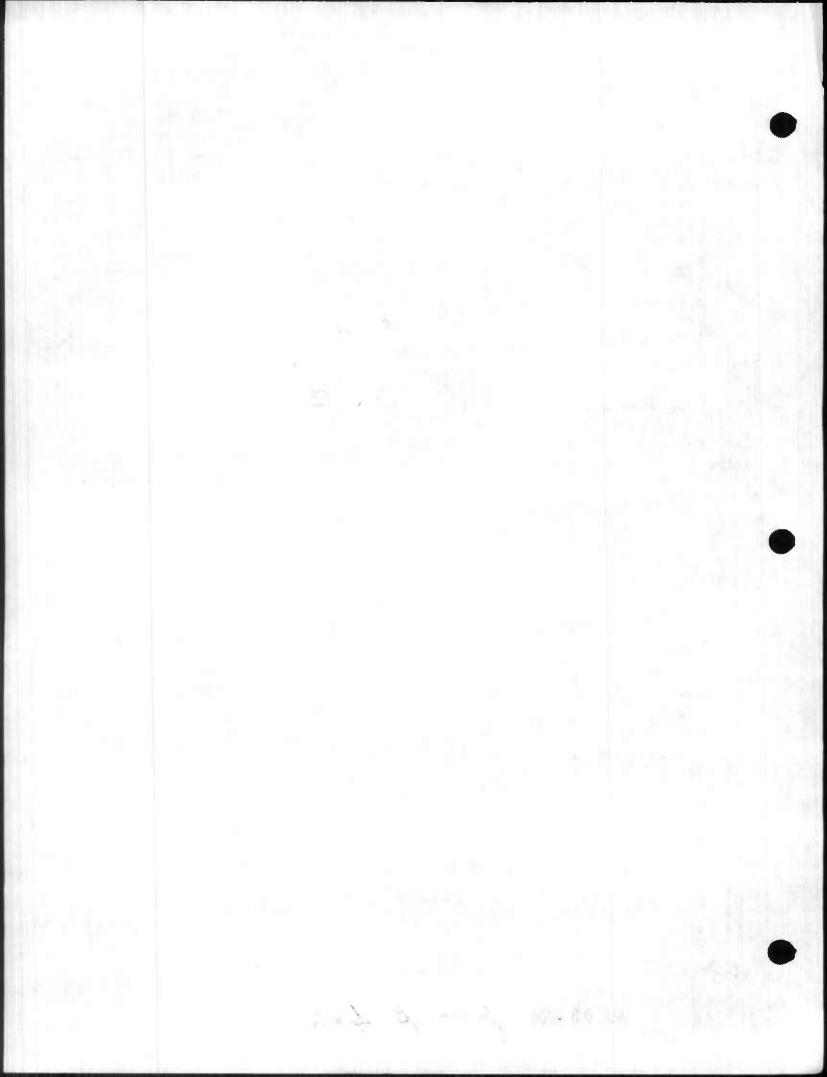
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Physician		1. Decedent's Neme (First, Middl	e, Last)								2. Date of D	eath D	ev	Yaar	3. Time of	Death
Physiciar /Medica	_	Horatio Reyno	1ds								AUX	mpt,	1,2	190	107	79
Examine		4a Facility Neme (If not institution	n, giva str	eet and num	nber)				4b. City, To	wn, or Lo	cation of Dea	ath 4	c. County	of Death		7
		Vantage House							Colum	bia		F	lowar	d		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)	If Und	er 1 Year Deys		24 Hrs. Min.	8. Dete of B (Month, L	irth	rl	9. Birthpl	aca (Stata o	r Foreig
Director		577-40-7468	1261 K	2 F	89	Yrs.	Wichiti	Joys	110010		June 1	6,19	11	Iow		
2	-	Usuel Residence of Decedent			1											
the state of		10a. Stata 10b. County			10c. C	ity, Town or Lo	ocation							10	Od. Inside Cit	
18	5	MD Hor	ward			columbi	a								1 🗆 Yes	X
0r 2l	Director	10e. Street end Number					10f. Z	ip Code				10g. C	itizen ot V	Vhet Coun	iry?	
23a		5400 Vantage Po	oint	Road			2	1044			USA					
E.5	Funeral	11. Marital Status			dent Evar in	J,S. 13.	Was Dec	edent of	Hispanic Ori	gin? (Spe	ecify Yas or N Ricen, atc.)	lo-		e - Amarica		
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	۵	3 ☐ Widowed 4 ☐ Divorced		It Yes, Give	a otes:		1 LI Yes	XXNo	Specify:				Specify	·	Whit	e
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d other avant, p	Be	17. Fathar's Nama (First, Middle,	Last)						18. Mothe	er's Neme	(First, Midd	le, Maide	n Sumem	10)		
	0	Perry Reynolds							Nora	Fen	Fenton					
		19e. Informent's Neme/Reletions	hip (Type	. Print)		19b. Meili	ng Addre	ss (Stree	t and Numb	er or Rure	r or Rurel Route Number, City or Town, Stete, Zip Code)					
ges I and 2 t of Health a if item 27 is or other tra	Doris Middlebrook/Niece 300 3rd Street, #									124.	San Fr	anci	sco.	CA	4107	
	1	Doris Middlebrook/Niece 300 3rd Street, # 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)									Dete			City or To		
		1 ☑ Buriel 2 ☐ Cremetion		novel from S	State	lingto	-			otor	w 8/10	Λ.	clina	ton	Virgi	nio
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Departmen Important: any injury once.		21. Signatura of Funeral Service	Licensee	0	no	0741 2			ess of Fecili	W.	itzke				-	
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hysician /Medical ixaminer		Immediate Ceuse (Finel disease or condition resulting in death)	a	me.		or es e conse			tul.	e	anc	er	•	1	2 yeu	x-
physician and s the bunal-transit	Examine	Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	5 b		Due to	(or es e consec	quence o	h):						1		
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0 0 7	18	Part II. Other eignificant condition	one contri	outing to de	ath but not re	sulting in tha u	indarlying	cause g	iven in Part	l.	23b. DI	d tobacc	o usa co	ntribute to	the cause o	of dear
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page 2	Completed										15	Yes	o (Pale]Yes 2□	Ma
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90	ום	25. Wes case reterred to medical examiner?		pitel:				0	ther: 1!		(Check only					
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after death Director: d in by the	D				best of my kn	owledge, deet	h occurre	d et the t	ime, date er	d pleca,	end due to th	e cause((s) and me	enner es st	eled.	,
n 24 hours after death he Funeral Director:, pletaly filled in by the	edical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physici Examine	: On the ba and mann	sis of examin	etion end/or In	vestigetic	on, in my	opinion, dee	th occurr	ed et the time	e, date e	nd pleca,	end due to	the ceuse(s	5)
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 2 4 5 3 1

			Certificate o	f Death	R	eg. No.	24001
D	Decedent's Name (First, Middle, Last)		200 70 100		2. Dete of Deel		3. Time of Death
Physician /Medical	RAYMOND FI	ELDING	REDGRA	7VES	AUGUS7		ear 07:08
Examiner	4e Facility Name (If not institution, give street a	nd number)		4b. City, Town, or I		4c. County of	
	HARBOR HOSP	TAL CEN	VTER	DACTI	MORE	I	V/A
Funeral Director	5. Social Security Number 6. Sex 1217 16 3833	7. Age (In yrs. last I	birthday) If Under 1 Yes Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day) Nov • 29	Year)	Birthplace (State or Foreign Country) Maryland
2 >	Usual Residence of Decedent	100 City To	num or l neetien				40d toolds Olbe Limits
the state of	10a. State 10b. County		own or Location				10d. Inside City Limits 1 2 Yes 2 □ No
Porto	Maryland N/A	Balt	imore				
r frams 23a or 28a-fe interment be notified Funeral Director	10a. Street and Number 600 Light Street Ar	ot. 333	10f. Zip Code 212	230		0g. Citizen of Wh	
by E.	1 Never Married 2 Nemied 15	s Decedent Ever in U,S. ned Forces? IYes 2 □ No 'es, Give er or Dates: W • W • I	1 ☐ Yes 2 🛣 N	f Hispanic Origin? (Suban, Mexican, Puert o Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black, Specify:	American Indian, White, etc. White
ygiene. ner than *natur. nt, tre Medical	15. Decedent's Education (Specify only highest grade comp Elementery/Secondary (0-12) Co		Sa. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	supetion ale during most of wor red)	king	16b. Kind of Busin	
Hygiene. ther than ent, me	8th	1090 (1 40) 01)	Truck Driv	er	4-1-1	Truckin	g Company
d other event,	17. Fether's Name (First, Middle, Last)		Sr		ne (First, Middle, I		
Mental arked o etic ev	Raymo	ond Fielding		M	ary Park	S	
ith and M 27 is mar traumat	19a. Informent's Name/Reletionship (Type, Pri	City or Town, St	ate, Zip Code) MD 21225				
Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than *naturally injury or other traumatic event, the Medical once. To Be Completed	20a. Method of Disposition 1 🛣 Burial 2 □ Cremetion 3 □ Remove 4 □ Donation 5 □ Other (Specify)	from State	of Disposition (Name of tery, crematory or other p r Hill Cemet		Dete 8/4/00	20c. Location - Ci	re, Maryland
hysician (Medical	23a. Part1. Enter the disease, or including shock, or heart failure.		o not enter the mode of d	chie Highw lying, such es cerdiad	ay Balt	imore, M	Approximate fnterval Between Onset and Death
xaminer	disease or condition resulting in death) a	Due to (or as	a consequence of):				6 doys
as the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):				
for u							
igned by the attending be detached for use by Physician/N	Part II. Other significant conditions contributing by YELOPROLIFERA 70.			given in Part I.			ibute to the ceuse of death □ Probably 4 ☑Unknow
ate hes been signed by the page 2 should be detached completed by Phys	SIDEROBLASTIC !				24a. Was a perfor		24b. Were eutopsy findings available prior to completion of ceuse of death?
is certificate hes t director, page 2 s	CHRONIC OBSTRU	CTIVE PU	LYONARY				t □ Yes 2 No
certifi rector	25. Was case referred to medical examiner?	l:		Mhar:	ath (Check only or		
60 U A	TI THE ZEE NO	129 Inpatient 2 LER/	Outpatient 3LI DOA	4 Li Nursing r	lome 5 Reside	ence 6 LOther ow injury occurred	
al Director: After tied in by the funera Certification:	1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Dete of Injury (Month, Dey Year)	o. Time of Injury M 1				
within 24 hours after of the Funeral Direct completely filled in by Medical Certifi	4 Homicide determined 28e	. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	08	281. Location (S. City or Town		or Rural Route Number,
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d Medical Certification: To	29a. Certifier (Check only one) Certifying Phyeician: 2 Medical Examiner: Or an	To the best of my knowled the basis of examination d manner stated.	ge, deeth occurred at the and/or investigation, in m	time, date and place y opinion, death occu	e, and due to the curred at the time, d	ause(s) and mani late and place, an	ner es steted. d due to the ceuse(s)
Within To the comp	29b. Signeture and title of certifier		29c. Lice	ense number	2	9d. Date signed	(Month, Day, Year)
/ \ \) Qe.	<u> </u>		5550	8	08/01	/2000
5	30. Name and address of person who complete			STREE T	BALTII	YORE, 1	40 21225
State	31. Date filed (Month, Day, Year) ALIG 0 3 2000	32. Registrar's Signature	A 1	1			



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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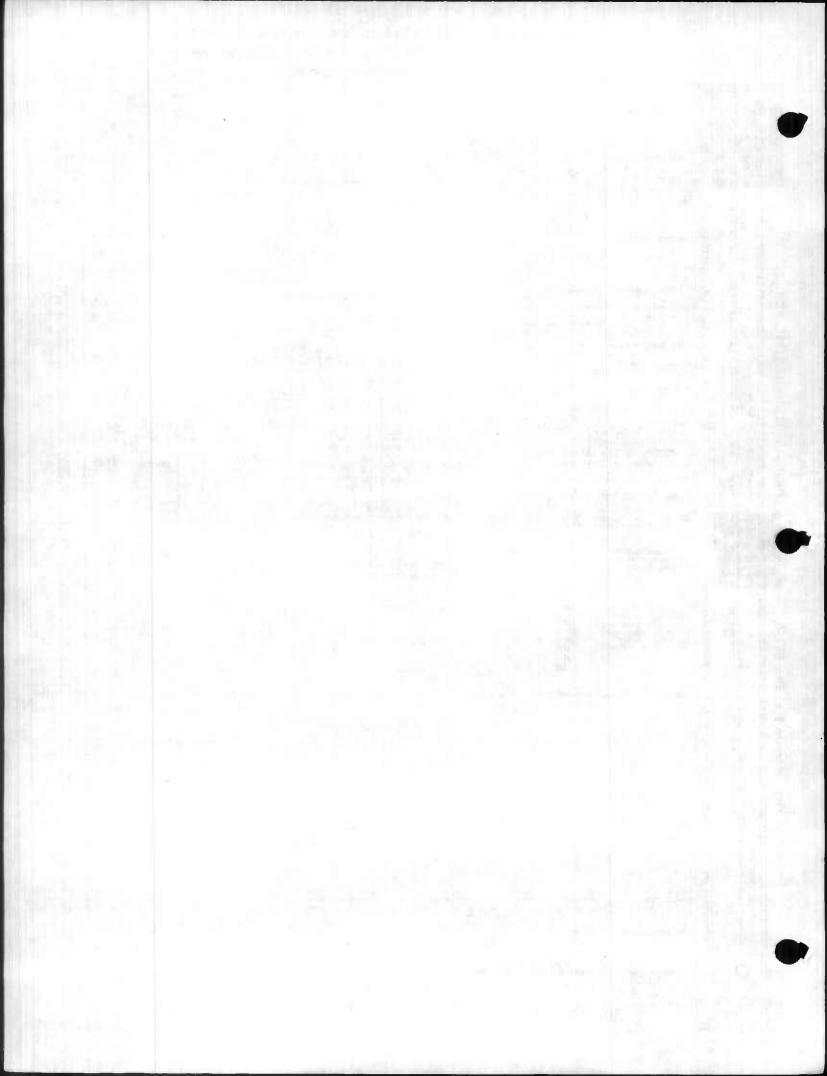
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						Cer	Tifica	e oi	Death	1		Reg. No.			•
ı	Physicia	_	Decedent's Nama (First, Middla, I Arduino	ası) Rossi							2. Data of D Month July	eath 31, Day 200	O Year	3. Tima of Death 5:45 PM	
	/Medic	-	4a Facility Nama (If not institution, g	iva street and number					4b. City, To	own, or Lo	ocation of Dea	th 4c. Cour	nty of Death		_
1	Examin	er								timo		N/			
ı			Future Care Car 5. Social Security Number 6.		a (In yrs. last	hirthday	If Unda	r 1 Yaa						place (State or Foreign	20
	Funeral		213-07-4370	10 M 20 F	94	Yrs.	Months			Min.	8. Data of Bi (Month, D 1-13-	4.986	Cou	placa (Stata or Foraig intry) Italy	
	Director	-	Usual Rasidanca of Decedant	A	94						1 13	1500		reary	_
	pud *	-	10a. Stata 10b. County		10c. City, T	own or Lo	cation							10d. Insida City Limits	S
	within 72 hours efter deeth with the Meryland ene. than "natural", or items 23s or 28s-f show the Medical Eserviner must be notified at	5	Maryland N/A			ltim								Yas 2□No	
	7 8 P	20	10e, Street and Number				401.70	0-4-				10g. Citizen o	6 MA - 1 O - 1	-1-0	
	E 8	Director		01			101. 21	Coda 212	24				S. A		
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0	or h		1 Nevar Married 2 Married	1 ☐ Yas 2X If Yes, Giva	No		I □ Yas					Spec	Tath	nite	
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21215-0020	72 hours	Completed	15. Decedant's (Specify only highast of	Education	1	6a. Deced	lant's Usu	al Occu	pation	st of work	ina	16b. Kind of	Businass/In	ndustry	
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B	年工長を	Be	17. Fathar's Nama (First, Middla, La	st)					18. Moth	ar's Nam	a (First, Middle	a, Maiden Sume	ama)		
a	lental ked c	10	Francesco	Rossi					Maria Rinaldi						
Maryland	should be end Mental e marked o		19a. informant's Name/Ralationship			19b. Mailir	g Addras	s (Stree	et and Numb	er or Rur	al Routa Numi	bar, City or Tow	n, State, Zi	ip Code)	
X	and 2 saith e n 27 is		Frances A. Rossi	(Daughter	,	10	F T	00 (Street	Tin	i+ 240	0 Pal+	imoro	, Md. 2120	12
9	-755	-	20a. Mathod of Disposition	(Daugireer	20b. Place	e of Dispo	sition (Na	ma of		, 011	Data	20c. Location			12
Baltimore	00 5		1 Burial 2 □ Cramation 3		cema	atary, cran	natory or	othar pl	etery	9	-4-00			, Maryland	1
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ш	70 E 9 9		Wallace	S- Broo	51,8		1050	You	ck Rd.	Tow	son, Ma	aryland	21204	4	
			23a. Part1. Enter tha disease, or co shock, or heart failure. List on	mplications that causa	d the death. [Do not ent	er tha mo	da of dy	ing, such as	cardiac	or raspiratory	arrast,		Approximate Interval Batween	
	Physician		Siron, or right failure. Elst on	y one outse on each										Onset end Death	
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_6	and and	X	Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Diseasa or injury	10	Dae to for es	a conseq	Uprice Oil		1	0					
68760	_ @ ~		Cause (Diseasa or injury that initiated avants	c. A-C)	ho	20	M	21	20	d	210	ano	,		
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o	the de	186	Part II. Other significant conditions	contributing to death b	out not rasultin	g in tha u	ndarlying	causa g	jivan in Part	l.	23b. Dic	i tobacco use	ontributa 1	to the cause of death	1?
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of Vital Records,	Physician: this certific rel director,	0	examiner?	Hospital:	ant 20ED	/Outpatien	t 3 D	04 0	Wher: 1			sidanca 6 🗆 C	What /Saga	64	
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	(1)		30. Nama and address of person wh	complated causa of c	death (Itam 23	la) (Type,	Print)		1 1			-	1		
	/		S. S. DANG M	V. N. 101	St 140	100	0	41	PA	Sal	Fina	a N	y al	21222	
	Stat	е	31. Data filed (Month, Day, Year)	32. Registr	rar's Signature	1	Loc	/		e Modern	- HUY	10	4		-
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State of Maryland / Department of Health and Mental Hygiene 10 21, 522

		Otato of Maryia		ficate of		R	eg. No.	240	33		
Physician /Medical	1. Decedent's Neme (First, Middle, Last) MILDRED	RHIN	EHAR	1RT 2. Date Mor			ite of Death onth Dey Yee		ne of Death 40 PM		
Examiner	4e Fecility Name (If not institution, give s	at.			4b. City, Town, or Li BALTIMO	ocation of Death	4c. County BAL	E, CO			
Funeral Director	217-14-4430	M 201 7. Age (In yrs		Under 1 Year lonths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 21	9. Birthplece (St Country)	ate or Foreign		
/land	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir										
ith the Marylar or 28a-f show a notified at	MD RAI	-Timore	Y	arkuil	le			10	Yes 20 No		
ifier deeth with the Mar frems 23e or 28e-fiel other mast be notified funeral Director	20 PARKWII	NO ICT.		10f. Zip Code	11734		0g. Citizen of W	het Country?			
Urs ours	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		S Decedent of Hes, specify Cub Yes 2 10 No	tispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American Indie k, White, etc.	te		
1 21215-0020 ed within 72 hours at yolene vor then "natural", or net, the Medical Example Completed by 8	15. Decedent's Edui (Specify only highest grade Elamantary/Secondary (0-12)	16a. Decedent (Give kind life. DO	s Usuel Occur d of work done NOT use retire	pation during most of work d)	ing	16b. Kind of Business/Industry					
s 1 and 2 should be filed wif s 1 and 2 should be filed wif the theath and Mental Hygien flem 27 is merked other that other traumetic avent, the To Be Com	17 Fether's Neme (First, Middle, Last)	Ala	18 6			e (First, Middle, i	e, Maiden Surname)				
Maryland d 2 should be file th and Mental Hy T is marked oths traumetic avant	RAYMOND BY		Cari		ShBroo						
Mar d 2 sh th end T is m traum	19a. Informent's Neme/Relationship (Ty	- 6 1	11	^	and Number or Aur	1	}	State, Zip Code)	,		
0 80 = 6	20a. Method of Disposition ↑□ Buriel 2 □ Cremetion 3 □ R	emoval from State	Plece of Disposition cometery, cremate	on (Name of ory or other pla	ce)	Date /		City or Town, Ste			
Baltimore, permit. Pages 1 ar Department of Hea Important: If New 2 any Injury or other pages.	4 Donetion 5 Other (Specify) MORETAND Centery 74/2000 BALTO. MD. 21. Signature of Funeral Service Licensee PARTLEY MILES FUNERAL Home CHTD.										
20249	23a. Pent 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. Colon Cancer with Lung Metastatic Disease Due to (or as e consequence of):										
oartificate be assecuted triple by secuted triple by secuted triple as the buriel-transit as as the buriel-transit AMedical Examiner											
Geath cert death cert e ettendin ed for usa	Pert II. Other significant conditions con	tributing to death but not re-	ven in Part 1.	23b. Did tobacco use contribute to the cause of death							
ds, P.O. Box ires that the death cer signed by the ettendir d be detached for usa d by Physician/N		1		1 Yes 2 70 3 Probably 4 Unknown							
Division of Vitai Records, P.O. Box or Attending Physician: The lew requires that the death cent after death. Director: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for usa ertification: To Be Completed by Physician/M						24a. Wes e	en autopsy med?	24b. Wera euto available p completion of death?	prior to		
The The Page						1□Y	es 20No	1 ☐ Yes	No No		
of Vitai Physician: The Physician: The this certificate ral director, page: To Be Co	25. Wes case referred to medical exeminer?	26. Plece of Deeth (Check only one) Hospitel: Management of Editors (Control of Editors									
on of V	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ury 28b. Time of 28		4 Li Nursing Home 5 Li		Residence 6 LiOther (Specify) ribe how injury occurred				
Division of Vital Record To the Hospital or Attanding Physician: The lew requir within 24 hours after decided. After this certificate has been a completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	2 Accidant investigation 3 Suicide 6 Could not be 4 Homicide detarmined	28e. Place of Injury - At h building, atc. (Speci	noma, farm, street,			28f. Location (S City or Tow	n (Street and Number or Rural Route Number, Town, Stata)				
Hospita 24 hours Funeral stely fille dical C	29a. Certifier (Check only one)										
To thy comp	290. Signature and title of certifier	29c. Licens		29d. Date signed (Month, Day, Year)							
,0	30. Name and address of person who co	-	m 23e) (Type, Prin		05372	- /	Hugues	01, 3			
State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	ature 4	1			/				

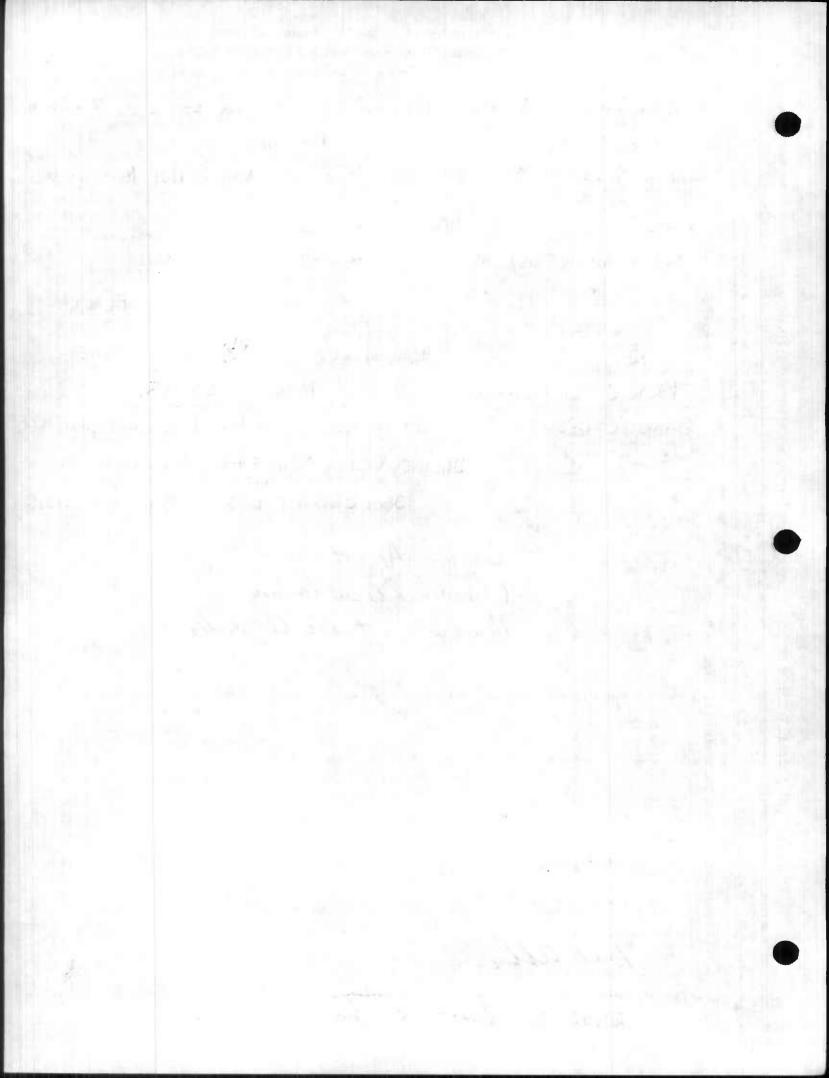


amend item 2 per phys. G786 8/10/00 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day 24 Yaa **Physician** ARGARIE SPENCER 7:25 AM July 3-12000 /Medical 4b. City, Town, or Location of Beath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE CENTER ff Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 9. Birthplaca (Stata or Foreign 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 A F 69 212-30-7022 Yrs. Director APRIL 24 1931 MARYLAND Usual Rasidence of Decedent 10c. City, Town or Location 10a. Stata 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYas 2 No BALTIMORE Directo MARYLAND

10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? USA 21229 234 AVE MUNASTERY Funeral 14. Race 12. Was Decedent Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. or Nema 11 Marital Status 1 Yas 2 No If Yas, Giva 1 Nevar Married 2 Married Baltlmore, Maryland 21215-0020 1 Yas 2 No Be Completed by BLACK Yaar or Datas: 'netural' 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry condery (0-12) College (1-4or 5+) HOME MAKER Home OWN other 18. Mothar's Nama (First, Middla, Meiden Surnama) 17. Fathar's Nama (First, Middla, Last) . Peges 1 and 2 should be fit trent of Heelth end Mental H tant: If Itam 27 is marked off ilury or other treumatic aver MARIE NESBI 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) SPENCER BALTIMORE, MD 2129 20c. Location - City or Town! Stata SAMUEL AVE 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata permit. Pege Department of Important: If any Injury or page. DULANEY VALLEY CEM 8-1-00 TIMONIUM, IND
22. Nama and Addrass of Facility NUTTER FUNERAL HOMES, FAC 4 Donation 5 Othar (Specify) 21. Signature of Funaral Sarvice Licenses 23a. Part 1. Entar tha disaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina. BALTS, MO 21216 Approximata Intarval Between Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical **Examiner** Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last P.O. Box 68760, ucocele Physician/Medicai signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yas 2 No 1 Yas 2 No or Attanding Physician: 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Hospital: 1 Inpatiant 1 Yas 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 5 Pending To the Hospital or Attanding within 24 hours aftar daeth.

To the Funeral Director: Afta completely filled in by the fun 1 Yas 2 No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, fectory, office building, afc. (Specify) 4 Homicide 16 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie 29c. Licansa number 0389 8/2/00 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) Found Aldans, MD, 2411W Belvedere
31. Data filed (Month, Day, Year) 32. Register's Signature BAITO, MO State AUG 03 Registrar



					State of Ma	aryland /	Departme Certifica		Health and I Death	Mental Hy	giene Reg. No.	0	24535		
			Decedent's Neme (First, Middle, Last)							2. Dete of De Month	eth Dey	Yeer	3. Time of Death		
	Physici /Medic		Stanley Schneider							August			2:40 a.m.		
	Examin		4a Facility Name (If not institution, give street and number) 4b. City, Town, or							ocation of Deet	cation of Deeth 4c. County of Deeth				
			Chesapeake Hospice House						Annapolis Anne Arundel						
	Funeral Director		5. Social Security Number 129–22–3269 6. Sex 1 M 2 F 69 1. Age (In yrs. last birthday) F (Inder 1 Yes) Months De							8. Dete of Birth (Month, Dey, Year) Oct. 4, 1930 9. Birthplece (State or For Country) New York			nplece (State or Foreign untry) York		
	p ,		Usuet Residence of I									10d. Inside City Limits			
	ahov	7	10a. State 10b. County 10c. City, Town or Location										1 ☐ Yes 2 ☐ No		
	No M	ecto	MD Anne Arundel Annapolis												
	the second	ă	10e. Street end Number									WINE COL	untry r		
Maryland 21215-0020 42 should be filled within 72 hours after deeth with the Meryland in and Maniel hygiene. The marked other than "natural", or items 23s or 28s-f show	23 me 23	era	907 Topm	ast way	12 Was Decedent	12. Wes Decedent Ever in U,S. 13. Wes Decedent			Hienanic Origin? (S.	nacify Vas or No	USA 14 Bac	a - Amer	ican Indien,		
	urs after d	by Funeral Director	11. Merital Stetus 1 Never Marrie 3 Widowed 4		Armed Forces?	Armed Forces? If Yes, specify 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑			ban, Mexican, Puert		o, etc.				
	ithin 72 ho e. en "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-			16a. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re			pation during most of wor ed)	16b. Kind of Business/Industry					
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Z	should be and Mentel marked o	2	Abraham				N 84-10- A 44-		Ruth Ma	Inn ral Route Number, City or Town, State, Zip Code)					
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Baitimore,	T H Or o		1X Burial 2	Cremetion 3	Removel from Stete					0.16.100					
	permit. Pa Departmer Important: any Injury		21. Signature of Fun	o □ Other (Specify eral Service Liver		well	wood Cen		4		Pinelaw uneral H				
Ba	Departition Departition Imports any Injuries		Kim	1 Da	h Panas	7 Moh	255/55 1	win	Knolls Ro	oad, Co	lumbia,		1045		
			23a. Part. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardlec or respiretory errest, Shock, or heart feiture. List only one cause of each line. Approximate Intervel Between Onset end Deeth												
A	Physician /Medical												1.		
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		Je.													
	outed nd ransit	dicai Examiner	Sequentially list con-	ditions.	b	Due to (or es e	consequenca of):							
8760, set be axecuted hysician and the buriel-transit		EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury												
8760,	sete b	dica	thet initieted events resulting in death) Le		C	Due to (or es a	consequence of):							
Box 6	nding p	Physician/Me		·	d							1			
	the attenthed for	sici	Pert II. Other elgnific	ant conditions o	ontributing to death b	ut not resulting	in the underlying	cause g	iven In Pert I.	23b. Did	23b. Did tobacco use contribute to the cause of death?				
P.0	\$ 50 B	Phy								1 □ Yee 202 No 3 □ P			obably 4 Unknown		
15,	signe bed	by									C4h Whos subsection				
Records,	w requires thet been signed t should be det	Completed								s en eutopsy omed?	6	Were autopsy findings eveilable prior to completion of cause,			
360	ha ha	d l		ELIC D			144				/		of death?		
ai	delan: The incertains rector, page		OF Mice coop referen	d (a madical					-0.01		Yes 2 No		Yes 20 No		
Vitai	Physician: this certific ral director,	To Be	25. Wes case referre examiner?		Hospitel:	ent 2 ER/O	Outpetient 3	0	ther:	oth (Check only Iome 5□ Res		her (Spec	6118		
of	문 문교	T:	27. Menner of Death	of Death urel 5 Pending ident investigation cide 6 Could not be	28e. Dete of Inju	ry 28b.	Time of	28c. Inju		,	how injury occu		Jours Jours		
ion	Attending For deeth. Sctor: After by the funer	atio	1 Neturel 2 Accident		(Month, Dey Year)				Yes 2□No						
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide		28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify)				28f. Location City or To	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					
	ital or is after is Dir led in				ounding, etc. (<i>Specify</i>)					Sily of Formit States					
	To the Hospital or within 24 hours after to the Funeral Direction ompletely filled in	edical	29a. Certifier (Check only one)	Certifying Ph	Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and plece, end due to the ceuse(s) and menner steted.								stated. to the ceuse(s)		
	To the	Ž	29c. License number 29d. Date signed (Month, Dey, Year)												
	1)	1	*CE	last	ULL	2		1	13/55	/	Hugu	st	2,2000		
	MARIN	11	Bussell Q, Delug 10 1600 S. (1910 Highway Stefa Chen Duny)										my/rd. 2106)		
	Sta Registr		31. Dete filed (Month		32. Registr	er's Signeture	& A	bon	6						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stevens **Physician** Month 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Newsins (U/usus) 9 OW91 5. Social Security Number If Undar 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** Months Days 1□M 2図 F Yrs. Director 262-32-7461 FLORIDA Usual Residence of Decedent the Marylend 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Director MD. HOWARD COLUMBIA 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? deeth with 8704 HUGO CT. 21046 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva ** Year or Dates: 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify. by Specify: BLACK 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mentai Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) -12-HOMEMAKER DOMESTIC 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK Be permit. Pages 1 end 2 should be to Depertment of Heelth end Mental Important: If item 27 is marked of any Injury or other traumatic eve LEROY McGILL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH K. STEVENS (SON) 8704 HUGO CT. COLUMBIA, MARYLAND 21406 20b. Placa of Disposition (Name of camatary, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SEABOARD CEMETERY 8-5-2000 QUINCY, FLORIDA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility REDD FUNERAL SERVICE 0 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final CGGCEL disaase or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the Due to (or as a consequenca of) use es ettending for use es P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 Yes 20 No 3 Probably 4 ☐ Unknown ement, a Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 2 No certificate 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Dursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral Certification: 27. Menner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. To the Hospital or Attendition within 24 hours efter death.

To the Funeral Director: A completely filled in by the fr 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 15 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Hickory Kelge Nel Columbia Med 2xy

Registrar

State

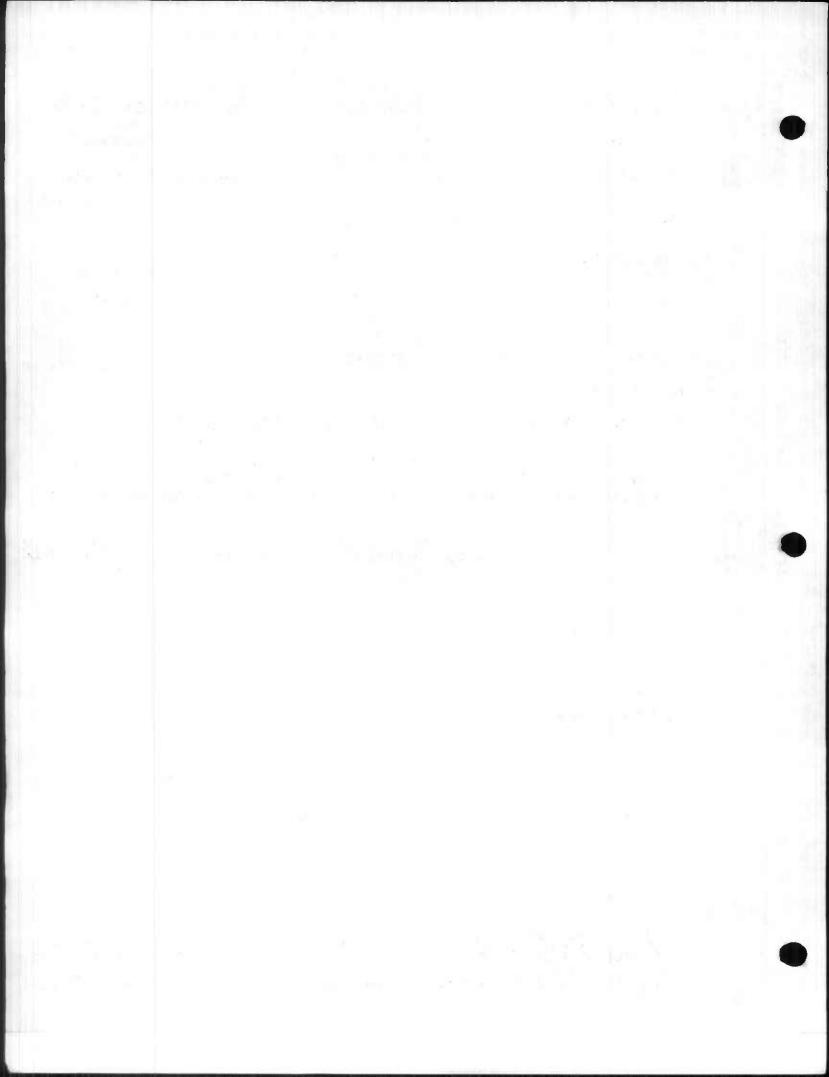
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32. Ragistrar's Signatura

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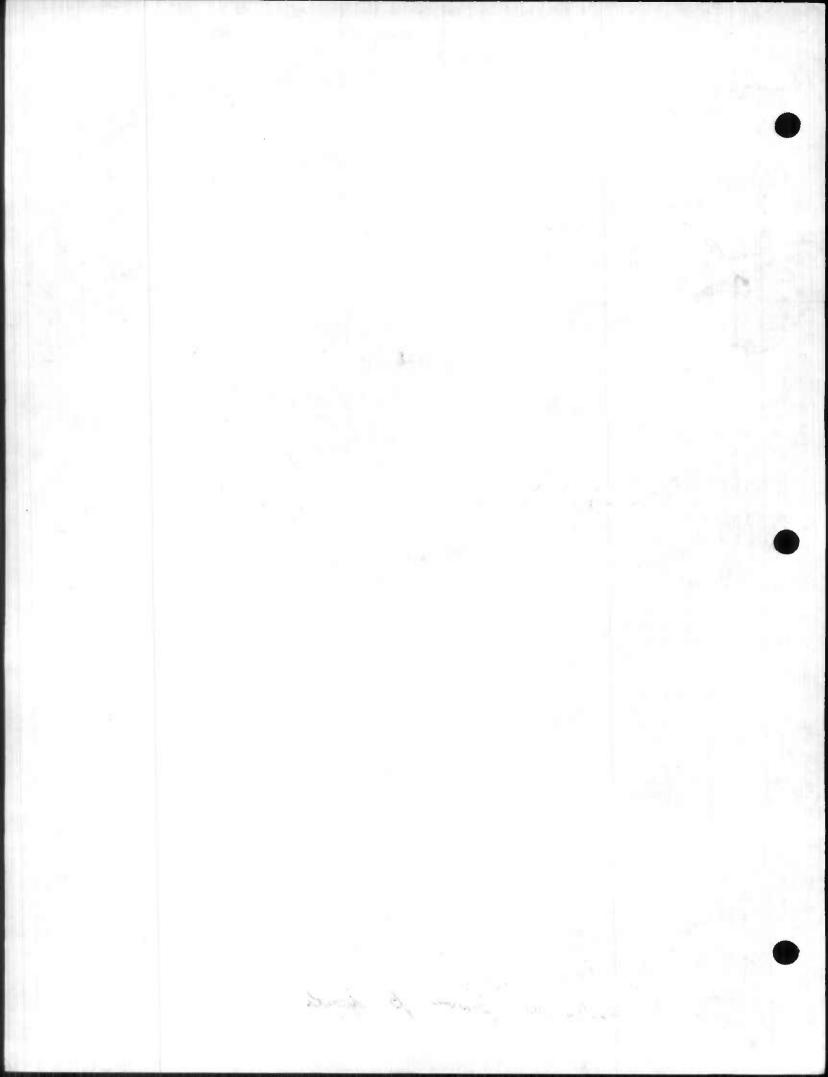
31 Date filed (Month



DENNIS TAYLOR

State of Maryland / Department of Health and Mental Hygiene 00 24537

AMEND I	TEMS: #23 PART]		Certific	ate of	Death	2. Data of D			Time of Death		
Physician						Month JUI_Y	Day 28	Year 2000	19:40 PM		
/Medical Examiner	Dennis Taylor 4a Facility Nama (If not institution, give	street and number)		4	b. City, Town,	or Location of Dee			17.40 111		
Examine	4101 SPIDER LILY	WAY			OWINGS	MILLS	BALT	TIMORE			
Funeral Director	5. Social Security Number 6. Se		ast birthday) If Ur Yrs. Mont	der 1 Yaer hs Days		Hrs. 8. Data of B (Month, D		9. Birthplaca Country) Marylar	(Stata or Foraign		
72 hours effect deein with the Menyland natural; or Items 23a or 28a-1 show order Eventual to notified at the Carton for the C	Usual Rasidanca of Dacedant 10a. Stata 10b. County	10c. City	, Town or Location					10d. I	Inside City Limits		
Ctor	Maryland Baltimore	9	Owings	Mills				1	1□Yes Z∏No		
3a or 28a-1 o at be notified al Director	10e. Street and Number 4101 Spider Lily			Zip Coda 2111	7		10g. Citizen of \	What Country?			
al, or items 23a or 28a-f show Example must be notified at by Funeral Director	11. Merital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forcas? 199 1 1 1 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1	_			? (Specify Yes or Nuarto Rican, atc.)	lo- 14. Rac Blac	e - American Ir ck, Whita, atc. Black	ndian,		
natural, rotes Ex	15. Decedant's Edi (Specify only highast grad		16a. Dacedant's U	Isual Occup	etion during most of	working	16b. Kind of B	usinass/Industr	у		
E DE	Elementary/Secondary (0-12)	Collega (1-4or 5+)	Wa. DO NO	Tusa retired	3)		State L	aw Enfo	orcement		
E 6	17. Fether's Name (First, Middle, Last)					Nama (First, Middl					
umatic event, the To Be Co	Willie Fullard				Daisy 1	Caylor					
	19a. Informant's Name/Ralationship (T					r Rural Routa Num			_		
r th	Daisy Taylor / Mo					altimore,					
5 = 5	20a. Method of Disposition 1 M Burial 2 Cramation 3 1 4 Donation 5 Othar (Specify,		lace of Disposition (amatary, cramatory rison For			08/04/00	Owings				
Important: I any injury o once.	21. Senature of Funeral Service Licens	1	- W - S		ss of Facility	Derrick					
	23a. Part 1. Enter tha disaasa, or comp shock, or heart failure. List only o	· 4				s Ave., B			Land 2121 proximate		
nend ial-transit Examiner	Immediata Causa (Final disaasa or condition resulting in death)	b	r as a consequence								
physician and s the burial-transit the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Entar Undarlying Causa (Disease or Injury	C	as a consequence	017.	n			1			
0.0	resulting in death) Last	Dua to (or	as a consequanca	of):				t : 			
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d by the latached	Part II. Other significant conditions co	ntributing to death but not rasu	ulting in the underlyi	ng causa giv	an in Part I.		Yes 2 No	3 Probabl	y 4 Unknown		
should should							is an autopsy formed?	evellat	autopsy findings ble prior to etion of causa th?		
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rector, per	25. Was casa rafarred to medical axaminar?					Daath (Check only	one)				
T T	1 X Yas 2 □ No			DOA Oth	4 LI Nursi	ng Homa 5 ☐ Ra			CENE		
fler ne	27. Manner of Death 1 Natural 2 Accidant invastigation 3 Sulcida 6 Could not be	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury		y at rk? Yas 2 □ No		28d. Dascribe how injury occurred 28d. Location (Street and Number or Rural Routa Number)				
el Direc led in by	4 Homicida datarmined	28a. Placa of Injury - At ho building, atc. (Specify	ma, tarm, street, fac	nory, office			own, State)	oer or noral no	idia ivaniber,		
To the Funeral Director: A completely filled in by the fu	29a. Cartiflar (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my know iner: On the basis of axaminat and manner stated.	wledga, daath occur ion and/or Invastiga	red at the tir tion, in my o	ma, data and p ppinion, daath o	place, and due to the occurred at the time	e cause(s) and m e, date and placa,	anner as stated and dua to tha	d. i causa(s)		
Comp Comp	29b. Signatura end titla of pertiller	1 0		29c. Licans	e number		29d. Deta signe	ed (Month, Day	, Year)		
37	· //	f N,M.	1	0.0	C.M.E.		JULY	29, 200	0		
1	30. Nama end addrass of pyson who c	ompleted causa of death (Itam		enn, S	treet,	Baltimor	e, Maryl	and 212	201		
State	31. Data filed (Month Day (1997) 3 2	000 32. Ragistar's Signa		Spa	Ka						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Yaar Earl Charles Tyson Sr. 2000 10:40 Am 31 Sulc If Under 1 Year If Under 24 Hrs. 8. Data of Richard 4a Facility Nama (If not institution, giva street and number) 4c. County of Death ANNE ARUNDEL NORTH ARUNDEL HOSPITAL 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1X M 2 F 214 20 1400 March 2, 1927 Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Yas 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Chelsea Road 21122 U.S. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. TX Yas 2 No If Yas, Giva 1 Nevar Married 2X Married 1 Yas 2 No Specify: If Yas, Giva Year or Datas:W.W. II White 3 ☐ Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Nama and Addrass of Facility

4001 Ritchie Highway

COLON

Longshoreman

214 Chelsea Road

20b. Place of Disposition (Nama of camatary, cramatory or other place)

23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Dua to (or as a consequence of): MULTIPLE DRUTTON

Dua to (or as a consequenca of):

MELLITUS

2 ER/Outpatient 3 DOA

28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

VENTRICULAR

MEMSTATIC

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatiant

28e. Data of Injury (Month, Day Year)

Md. State Veteran Cem.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Examiner

15. Decedant's Education (Specify only highast grada completed)

1X Burial 2 Cramation 3 Ramoval from Stata

DIAGETES

5 Pending invastigation

6 Could not be detarmined

Collega (1-4or 5+)

John S. Tyson

manuourper

Elementery/Secondary (0-12)-12th

17. Fathar's Nama (First, Middla, Last)

Mary Ann Tyson

4 ☐ Donation 5 ☐ Othar (Specify)

21. Signature of Funeral Service Licensee

20a. Mathod of Disposition

Immediata Causa (Final

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that Initiated avants rasulting in death) Last

25. Wes casa rafarred to medical

29b. Signatura and titla of cartifian

1 Yas 2 No

axaminar?

27. Menner of Deeth

Natural

2 Accident

3 Suicida

29a. Cartifiar (Check only one)

4 Homicide

disaasa or condition rasulting in death)

19a. Informant's Name/Ralationship (Type, Print)

Funeral

Director

28s-f

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23a

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Maryland 21215-0020

Pages 1 and 2 should

* or other tra

The law requires that the death certificate be executed the burial-trans Physician/Medical SE. for use signed by the at t be detached for Be Completed by certificata or Attending Physician: after deeth.

Director: After this certifica director,

Box 68760. P.O. Records, Division of Vital

Medical Certification: To To the Hospital or within 24 hours aft To the Funeral Di completaly filled in State

DHMH 16 Rev 6/95

the

á

Registrar

31. Date filed (Month, Day, Y AUG 0 3

MD

29c. License number

Certifying Physician: To the bast of my knowledge, deeth occurred et tha tima, data and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date end place, and dua to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

16b. Kind of Businass/Industry

20c. Location - City or Town, Stata

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy performed?

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

26. Place of Death (Check only ona)

1 Yas 20 No

28d. Describe how injury occurred

Crownsville, Maryland

Approximata Intarval Betwe Onset and Death

24b. Wara eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Shipping

Pasadena, Maryland 21122

Gonce Funeral Home P.A.

Baltimore, Md. 21225

18. Mother's Nama (First, Middle, Maiden Surnama)

Data

8/3/00

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Augusta Brown

30. Nama and addless of person who complated causa of death (Item 23a) (Type, Print)

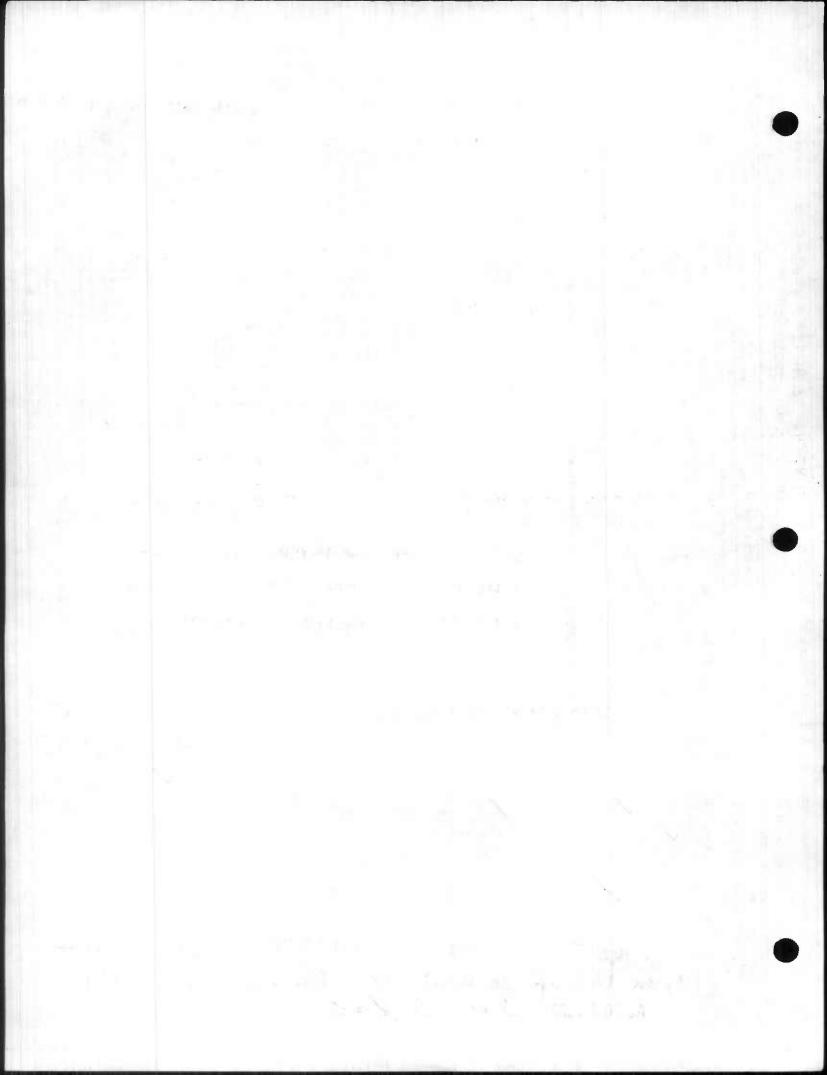
alen Burne, mo MERC

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

2000.

301 32 Registrar's Signatura



				State of Mary		epartment of Certificate of			iene () (og. No.	24539	
	D 1 - 1 - 1		1. Decedent'a Name (First, Middle, Last)					2. Date of Death Month	Day	3. Time of Death	
1	Physici /Medic	_	HELEN			WUNDER			8, 200		
	Examir		4a Facility Name (If not institution, give s			The state of		Location of Death	4c. County		
			JOHNS HOPKINS		for a filled	hday) If Under 1 Yea	BALTIMO		N/A		
L	Funeral Director		5. Social Security Number 213-12-4088 6. Sex Usual Residence of Decedent	7. Age (In	79 v	rs. Months Days			1	Birthplace (State or Foreign Country) MD	n
	vith the Maryland t or 28a-t show be notified at	tor	MD . 10b. County	100	BAL!	or Location FIMORE				10d. Inside City Limits X☐ Yes 2 ☐ No	
	h with the 23a or 28s at be not	al Directo	10a. Street and Number 305 S. CLINTON	ST.		10f. Zip Code	2122	4	og. Citizen of W USA	hat Country?	
020	ural, or flams	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of If Yes, specify Cu		Specify Yes or No- to Ricen, etc.)	Black	e - Americen Indian, k, White, etc. WHITE	
15-0	72 h	eted	15. Decedent's Educ (Specify only highest grade		16a. I	Decedent's Usual Occu (Give kind of work don- life. DO NOT use ratin	pation during most of wo	orking	16b. Kind of Bu	siness/Industry	
212	within the Man	Completed	Elementary/Secondary (0-12) 6 TH	College (1-4or 5+)		PACKER	90)		FACT	ORY	
Maryland 21215-0020	lid be liled fental Hyg rked other dic event,	o Be C	17. Father's Name (First, Middle, Last) EDWARD HILKER					me (First, Middle, N ZIOLOWS)		э)	
	and 2 sho saith and N n 27 is ma or treams		19a. Informant's Name/Relationship (Type NANCY THANNER/D	AUGHTER	3					Stete, Zip Code) MD. 21224	
Baltimore	Pages 1 ment of Hant if there		20a. Method of Disposition 1 □ Qurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery	Disposition (Name of r, crematory or other pl HOLY REDE		TO THE REAL PROPERTY.		City or Town, State	
Balt	Depart Depart Import any inj		21. Signature of Fuparat Service License			CHARLES 6224 EAS		ER & SOL	N INC	, MD. 21224	
			23a. Part1. Enter the disease, or compli- shock, or heert failure. List only on	e ceup on each line.	death. Do n	ot enter the mode of dy	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Finel		1	->-=/				Onset and Dealis	
	Examiner		disease or condition resulting in death)	Due	to (or as a c	crsLS onsequence of):					
	D =	Iner									
	be axecuted ician and burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate	Due	to (or as e c	onsequence of):					
760,	be assoul	calE	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
687	ficate phys	-	resulting In death) Last	Due	to (or as a co	onsequence of):					
Вох	death certifica e attending ph of for use as th	III/M	d		_						
	death e atte	sicla	Part II. Other significant conditions conf	tributing to death but no	t resulting in	the underfying cause of	iven in Part I.	23b. Did to	bacco use con	ntributa to the cause of death	1?
s, P.O.	ires that the death certificate be assou signed by the attending physician and d be deteched for use as the burial-trai	by Physiclan/Med						1 🗆 Ye	2 2 ho	3 Probably 4 Unknow	٧n
Division of Vital Records,	peen peen shoul	Completed						24e. Was er perform	n autopsy ned?	24b. Were autopsy findings aveilable prior to completion of cause of death?	
R	The law ate has page 2	Com						1□ Ye	s 2000	1 ☐ Yes 2 No	
/ita		Bec	25. Was cese referred to medical examiner?				26. Place of De	eth (Check only on	9)		
> 5		2	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient	2 ☐ ER/Out	patient 3LI DOA		Home 5 Reside	nce 6 Othe	er (Specify)	
sion o	or Attending Patier death. Director: After t	ation:	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Yea	ar) 28b. Ti	jury W	ury et ork?] Yes 2 No	28d. Describe ho	w injury occurre	ad	
Divis	is after de of Directo	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, far pecify)	m, street, factory, office		28f. Location (St. City or Town		er or Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my er: On the basis of exar and menner stated.	knowledge, mination and	death occurred at the Vor investigation, in my	time, date end plac opinion, death occ	e, end due to the ca urred at the time, da	use(s) and mai ate end place, a	nner es stated. and due to the cause(s)	
	With To t	Σ	29b. Signature and title of certifier			29c. Licer	nse number	25	9d. Date signed	(Month, Day, Year)	
	1		Timothy	The,		210			July	28,2000	
	5		30. Name and address of person who con	mpleted ceuse of death		Type, Print) Hern Ave	Baltin	nore 4	0 2/2>	14	

DHMH 16 Rev 6/95

Registrar

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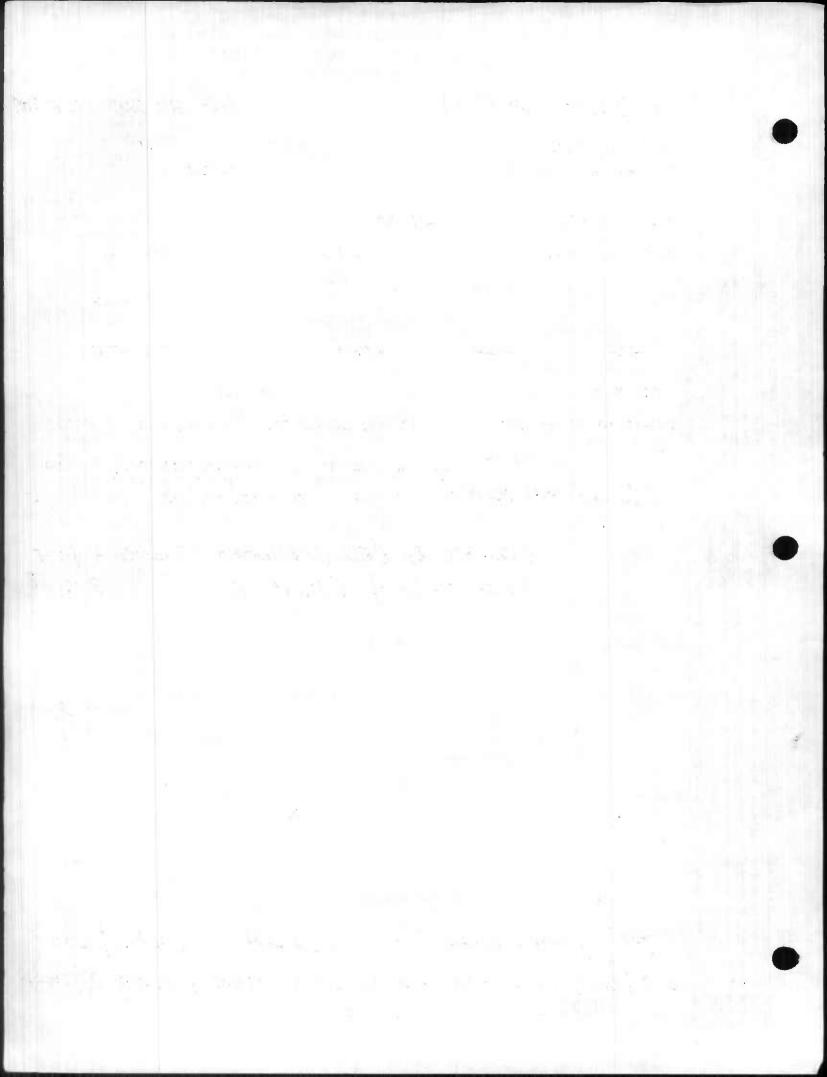
AUG. 3 2030 James

State of Maryland / Department of Health and Mental Hygiene []

24540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 1) 12/10/1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VILLA ST. MICHAEL BALTIMORE if Under 24 Hrs. | 8 if If Under 1 Year 8. Date of Birth (Month, Day Year) 8-25-1922 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 1♥ M 2□ F 215-14-5048 77 Yrs. SC Director Usual Residence of Decedent the Marylend r 28a-f ahow 10a Stefe 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Tyres 2 □ No Director BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or Items 23s or 2801 VIOLET AVE. 21215 USA permit. Peges I and 2 should be filed within 72 hours efter death a Depentment of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mantel. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A' Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, efc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK Aq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) LABORER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) EDDIE WYLIE MARY WYLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1235 E. LANVALE ST. BALTIMORE, MARYLAND 21202 JESSIE WILLIS (FRIEND) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY 8-4-2000 BALTIMORE, MARYLAND 22. Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of Funeral Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the deafh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** ELL CARCINOMA OF LUNG /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner end I-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician er s the bunal-ti Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 80 for use es signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably July Unknown by 24b. Were autopsy findings evallable prior to s need should Completed 24a. Wes an autopsy performed? completion of cause of death? irector, page 2 s The 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Pending daath. 1 Yes 2 No investigation Offector: A Jin by the f 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Dire letely filled in b 29a. Certifier Medicai 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signaturu a 29d. Date signed (Month Day, Year) 29c. License number Treenspling 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Dey 30 Roy Herman Arnett JUNE 2000 4:40 P.M. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□ F Yrs. 373-28-0920 Director May 20, 1923 Tennessee Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 23465 Kingston Creek Road 20619 USA Funeral Barras. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: à 3 ₩ Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6th Grade Farm Equipment Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Mary Unknown Maddox Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619 19e. tnlorment's Nama/Relationship (Type, Print) of Health Nem 27 is Elizabeth A. Fryman (Daughter) 23465 Kingston Creek Road, California, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 7/10/2000 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility 24 Mattingley-Gardiner Funeral Home, P.A. mer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Approximately Approximate Interval Between Onset and Death **Physician** week /Medical tmmediete Cause (Finat meemonia diseese or condition resulting in death) Examiner Due to (or es e consequence of): Few months Physician/Medical Examiner vere COPD Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es e consequence of): month deoression Box 68760. the the Due to (or as a consequance of): HERMAN ARNETT 88 950 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 40 Unknown Be Completed by 24a. Was en eutopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death? page 2 certificata has 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Date ol Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury el Work? After 5 Pending investigation Neturat after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide ò To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 6.30.00 0 D 47066 30. Name end address of person who completed causa of death (Item 23a) (Type, Print) PHILIP J.BEAN MEDICAL CENTER HOLLYWOOD, MD. 20636 AVANI D.SHAH M.D. 31. Date lited (Month, Day, Year) 32. Registrar's Signature State JUL 0 7 2000 oaks Registrar

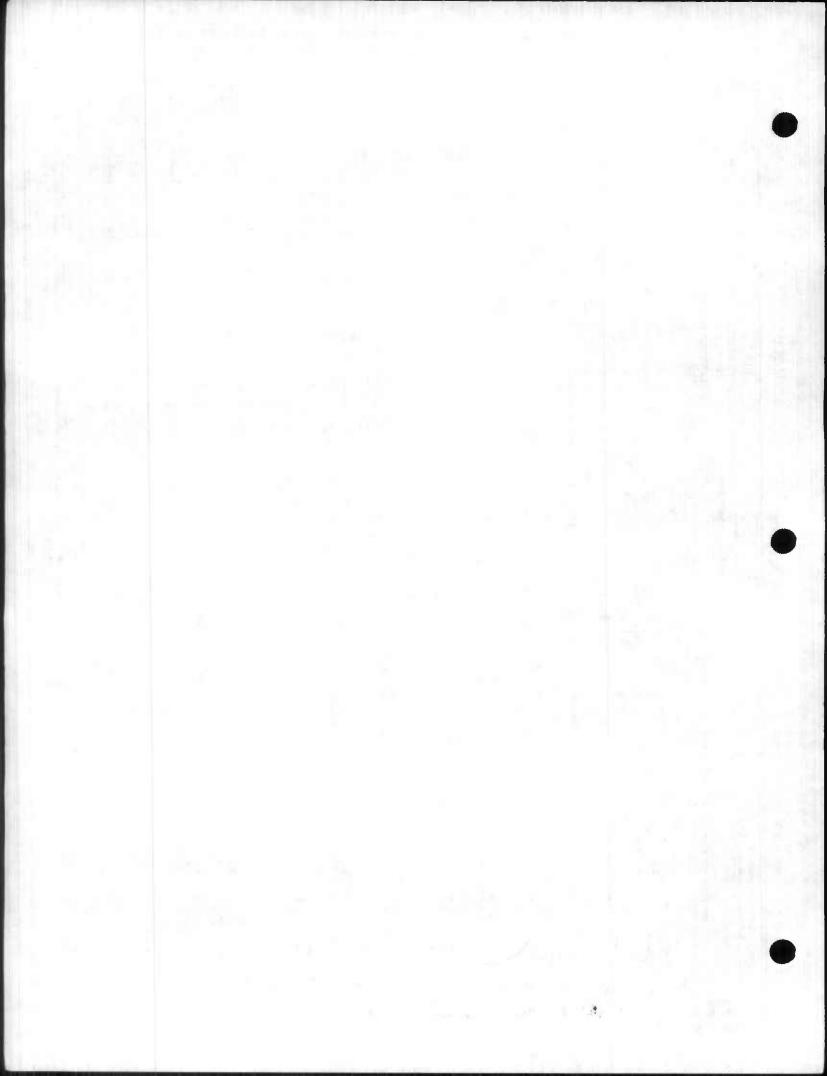
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State of Maryland / Department of Health and Mental Hygiene 10 24542

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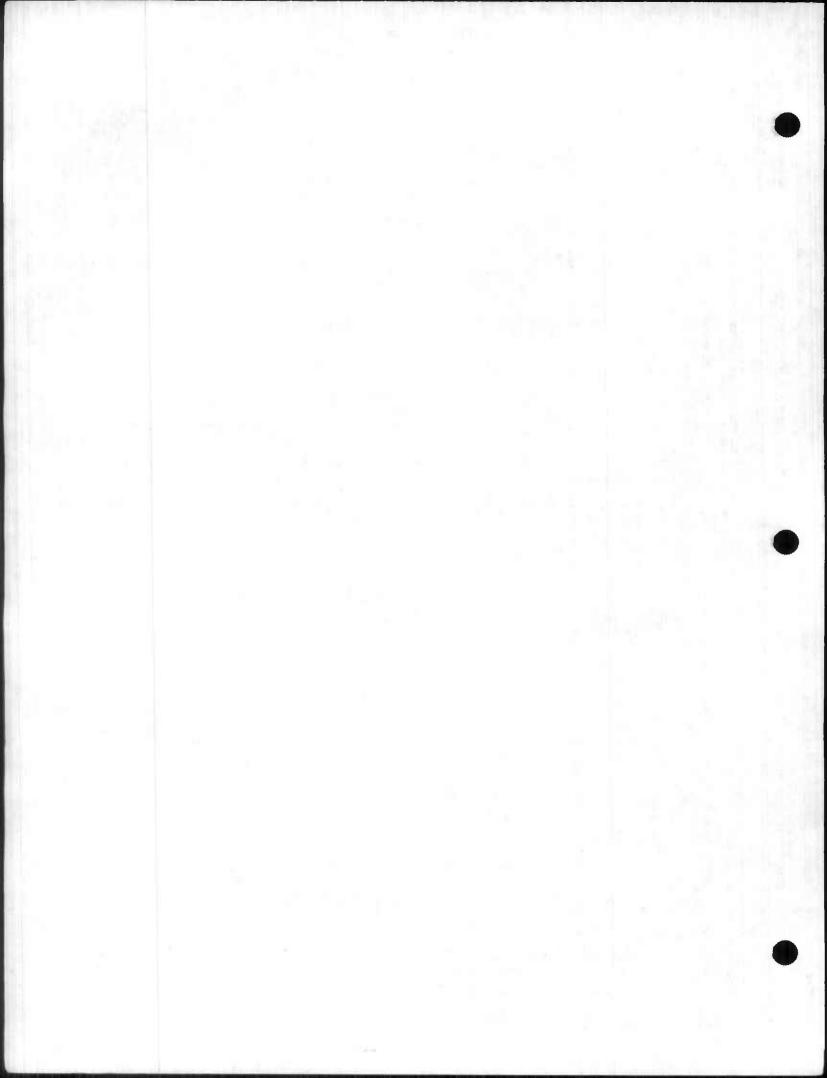
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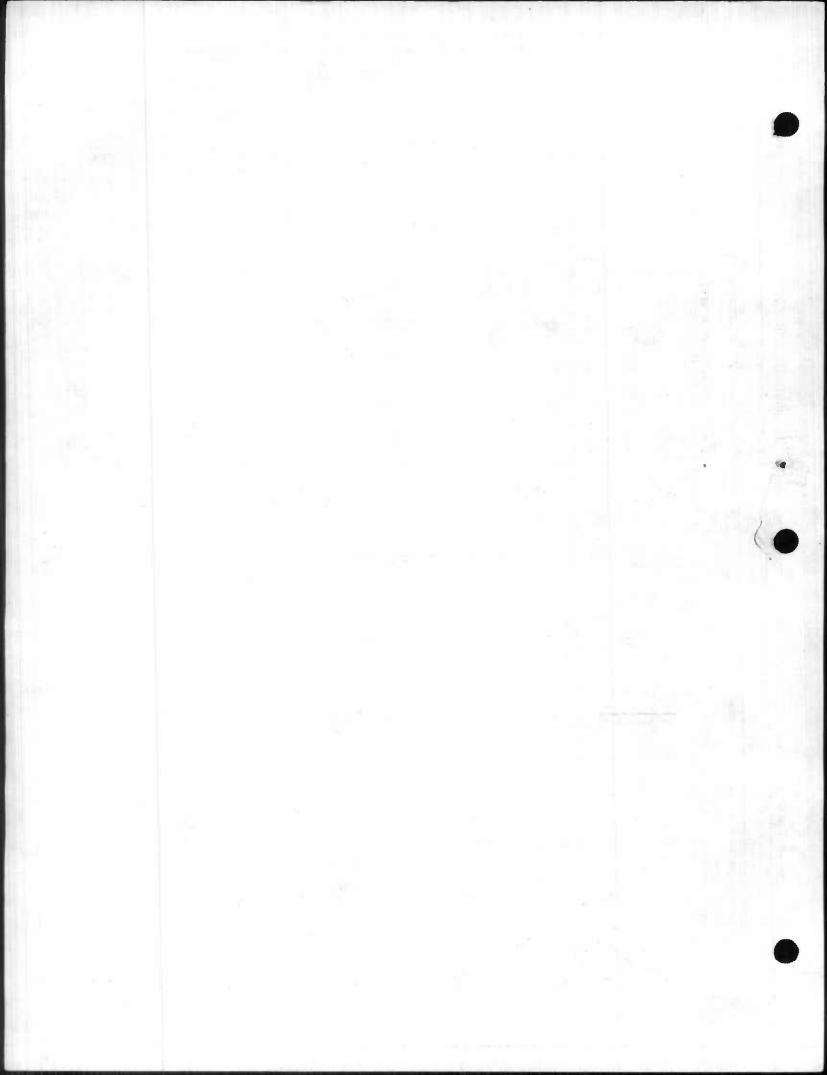


State of Maryland / Department of Health and Mental Hygiene 00 24543

			C	ertifica	te of	Death		R	leg. No.	0	C 40 0 45
	1. Decedent's Name (First, Middle, Last	()						2. Date of Dea		Mari	3. Time of Death
Physician	EIPTT 12 INTOIN							Month	22 2	COO	0530
/Medical Examiner	de Pestitu Name (14 met institution also					4b. City, To	wn, or Lo	cation of Death	4c. County		
Examine	Howard County Ger	neral Hosp	ital		- 1	Colum	hia		How	ard	
-	5 Social Security Number 6 Se	7 Ann (II	yrs. last birthde	lf Unde	r 1 Year	If Under		8. Date of Birth		9 Birthn	lace (State or Fore
Funeral Director	330-24-4375 H	9 M 2□F 8:		Months	Deys	Hours	Min.	Sept 12	2, 1918	Loui	siana
pu *	Usual Residence of Decedent 10a, Stete 10b, County	10	c. City, Town or	Location						1	0d. Inside City Lim
within 72 hours after deeth with the Maryland one. than "natural; or items 23a or 28a-f show he Madeal Emerine runt be rectified an immiested by Furnaral Director.			Fult								1 ☐ Yes 2 🗗
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3a o		nad			207	59			Unite	od St	ates
frer deeth viner result	11. Marital Slatus	12. Was Decedent Eve	r in U,S. 1	3. Was Dece			igin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	en Indian,
The Part of Pa	1 ☐ Never Married 2€ Merried	Armed Forces? 1√2 Yes 2 No						Hican, etc.)	Blac	k, White,	etc.
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n 72 hours natural', o cal Ext			16e. De	cedent's Usi	al Occur	pation			16b. Kind of Bu		
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	Elementary/Secondary (0-12)	College (1-4or 5+)	Chi	ef of	Curr	nlv			Federal	CON	rerment
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4 4 4	19e. Informent's Neme/Relationship (T)	ype, Print)	19b. M	ailing Addres	s (Street	end Numb	er or Run	al Route Numbe	r, City or Town,	Stete, Zip	Code)
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T He I	20a. Method of Disposition		20b. Place of Dis cemetery, of	sposition (Na rematory or	ame of other ple	ce)	i	Date	20c. Location -	City or To	wn, State
	1 □XBurial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify)		Resurre	ction	Ceme	terv	7.	-26-2000	Clinto	on. M	D
	21. Signature of Funeral Service Licens										
Docarta Importa any inju	Dama all							Family E			
										ity,	MD 21043
	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not	enter the mo	de of dyi	ng, such as	cerdiac	or respiratory are	est,		Approximate Interval Between
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death certificete be executed e attending physicien and ed for use as the buriel-transit sician/Medical Exemis	Sequentially list conditions, if any, leading to immediale ceuse. Enter Underlying Cause (Disease or Injury	Due	to (or as a con	sequence or):						
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the a	Part II. Other signiffcant conditions co	ntributing to death but n	ot resulting in th	e underlying	ceuse gi	ven in Part	1.	23b. Dfd t	obacco use co	ntribute to	o the cause of dea
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plett		end menner stated									30(0)
within 2 To the comple	29b. Signature and title of certifier			25	c. Licen:	se number		2	29d. Date signe	d (Month,	Dey, Year)
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item	23a per md G786 8/2/00 yg State of Maryland / Department of Health and Certificate of Death	d Mental Hy	rgiene 00	24544
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ysician Medical	MATCOTM M ATTEN	June	18 200	
aminer	An Constitution of the extension of the standard and purposes	or Location of Deet		
-	Genesis ElderCare - The Pines East 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If			lbot
eral ctor		Ain. (Month, De	24, 1914 M	Inthplace (Stete or Foreign Country) ARVIAND
	Usuel Residence of Decedent	DIII	27, 1717 11	III IIII II
H Y	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
ecto	MD TALBOT EASTON			X□ Yes 2 □ No
Ö	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
Funeral Director	204 AURORA ST. 21601 11. Meritel Stetus 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	/ (Specify Yes or No	USA 14. Bace - Ar	nerican Indian,
by Fun		uerto Rican, etc.)	Bleck, W	
Pe	15. Decedent's Education 16a. Decedent's Usual Occupation (Conditional Michael And American Medical Michael And American Medical Michael Micha	undina	16b. Kind of Busines	ss/Industry
Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+)	WOIKING		
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	JEANNE MITCHELL/PERSONAL REP 31307 KINGSTON RD EA			, eq. 000d)
	20e. Method of Disposition 20b. Plece of Disposition (Name of	Dete Dete	20c. Location - City	or Town, State
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SUCE.	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility			
00	Joseph m. Osfrowski FELLOWS, HELFENBEI			HOME PA
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as care shock, or hear failure. List only one cause on each line.			Approximate Intervel Between
an	Shoot, of fleat failure. List only one cause on soon line.			Onset end Death
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Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying			
CB	Cause (Disease or injury that initiated events			
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ysiciar	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	tobacco use contribu	Ite to the cause of death?
by Ph	Cente Chionie alcoholism	_ 10		Probably 4 Unknown
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lon	1 Neturel 5 Pending (Month, Day Year) Injury Work?	260. Describe	how injury occurred	
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Certification:	4 Homicide building, etc. (Specify)		wn, Stete)	
edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plut (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, death or one)	ece, end due to the courred at the time,	cause(s) end menner date end placa, end d	es steted. lue to the cause(s)
complately filled in by the funer Medical Certification:	29b. Signeture and title attention 29c, License number	-1	29d. Date Joned (Mo	onth, Dey, Year)
	03528	7	6/19/0	0
	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	1 01	5-04	m021601
		on st	Easton	mucieu
State strar	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture			
otrai	JUN 63 (2000 / / / / /			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24545 Certificate of Death 2. Data of Death 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death June 30, 2000 **Physician** 6:55 AM Baker Andrew /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 16699 Bennett Court Ridge St. Mary's If Undar 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F 216-40-5123 57 January 8, 1943 Director Maryland Usual Rasidence of Dacedent the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Francisco must be notified at 1 ☐ Yas 2 ☒ No Director Maryland St. Mary's Ridge 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 16699 Bennett Court 20680 USA Funeral deeth Wes Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 72 hours after 1 ☐ Yas 2 No 1 ☐ Never Merried 2 X Married 21215-0020 "natural", or 1 Yas 2₺ No Specify: Specify: à Black 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: if flem 27 is marked other than "na any injury or other traumatic event, the 14 december 2. Elemantary/Secondary (0-12) Collega (1-4or 5+) 11th Grade Roofer Self Employed Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be James Richard Baker Catherine Louise Countess 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) Mary F. Baker (Spouse) 16699 Bennett Court, Ridge, Maryland 20680 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Charles memorial Gardens 7/6/2000 Leonardtown, Maryland 22. Name and Addrass of Facility.
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funaral Sarvice Licensi rainer P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** one /Medical Immediata Cause (Final diseasa or condition rasulting in death) Lung concer year Examiner Dua to (or as a consequence ot): Examiner physician end the burial-transit The law requires that the death certificeta be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence ot): Box 68760, Physician/Medicai Due to (or as a consequence of): 88 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? P.O. 1 Yss 2 No 3 Probably 4 Unknown Records. à 24b. Wara autopsy tindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Was casa ratarred to medical axaminar? Be 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation or Attending Natural in 24 hours after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, tarm, straat, tactory, office building, atc. (Specify) in by 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Cartifiar completely s (Check only one) within 2 To the I \$ 29b. Signature and titla of certitian 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 31. Data tiled (Month, Day, Year) JUL 0 7 2000

Scoaby

30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

M. D.

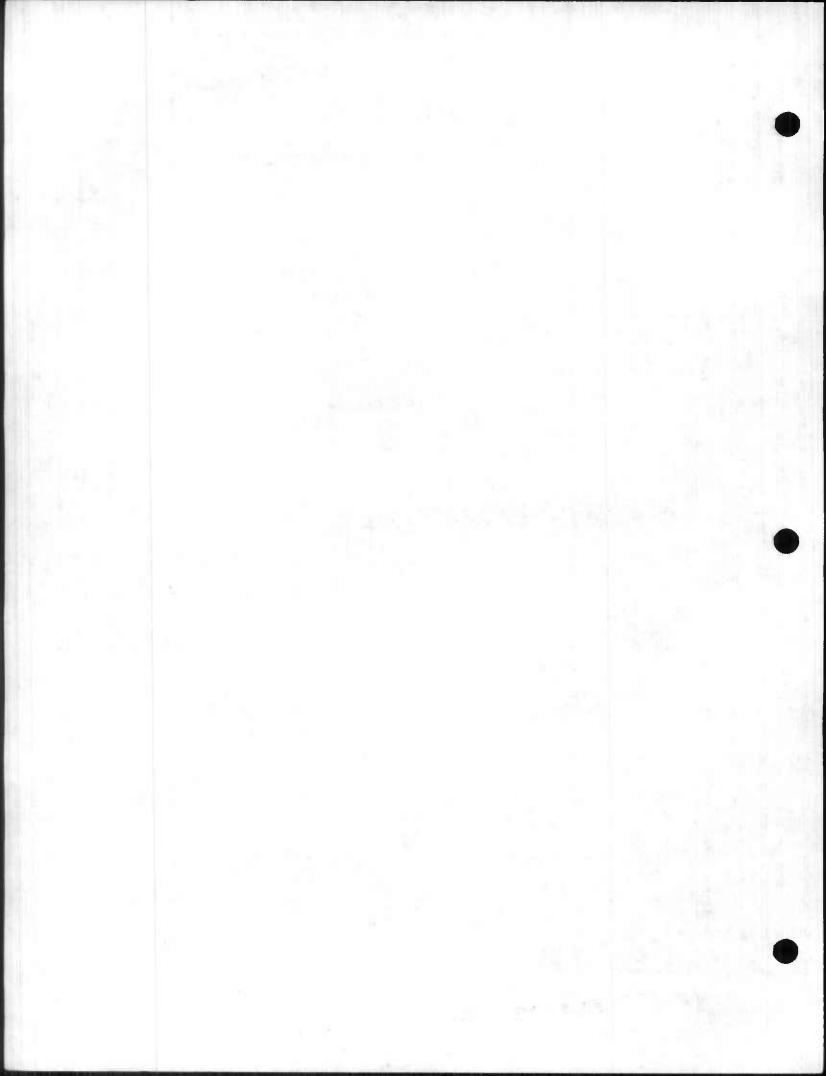
Hollywood, Maryland 20636

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Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Memorial Hospital Frederick Frederick Societ Security Number 236-74-2862 236-74-2862 102 Maryland Frederick New Market 102 Government New Market 102 Government New Market 103 June Hospital County Maryland Frederick New Market 104 June Steel 100 County Maryland Frederick New Market 105 Steel and Number 7155 Masters Road 110 Memorial Maryland 28 Memorial 110 Memorial Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial 110 Memorial Memorial Memorial Memorial 110 Memorial Memorial Memorial Memorial 110 Memorial Memo				C	ertifica	te of	Death		Reg. No.	10	24546
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physiclan** Month Day Margaret B. Benford July 19, 2000 11:55 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25608 Bushey Heath Rd. St. Michaels Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Deys 1□ M 2♥F Months Yrs. 074-38-3945 86 July 19, 1914 New York Usual Residence of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Talbot St. Michaels 10e Street end Number 10f. Zip Code 10g. Citizen of What Country? 25608 Bushey Heath Rd. 21663 Funerai U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working iffa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Be 2 Clarence Baily Lorena Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Jay R. Benford/Son 605 Talbot Suite 1, St. Michaels, MD 21663 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7-21-00 Cambridge Crematory Cambridge, MD 21. Signature of Funeral S 22. Name and Address of Facility Cambridge Crematory, P.O. Box 1464, 2272 Hudson Rd., Cambr Caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, ob each lina. 2272 Hudson Rd., Cambridge, MD 21613 Approximate Intarval Between Onset and Death Meshel cell carenini Immadiate Cause (Final 9months disease or condition rasulting in death) Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Cause (Diseasa or injury Dua to (or as a consequence of): that Initiated evants resulting in death) Last Due to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of ceuse of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese raferred to medical axaminer? 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 Pasidence 6 □Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural

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altimore, Maryland 21215-0020

the Medical Examiner must be

Examiner Physician/Medical Be Completed To : After this funeral Certification: To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fune Medical

5 Panding Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Cartifier (Check only

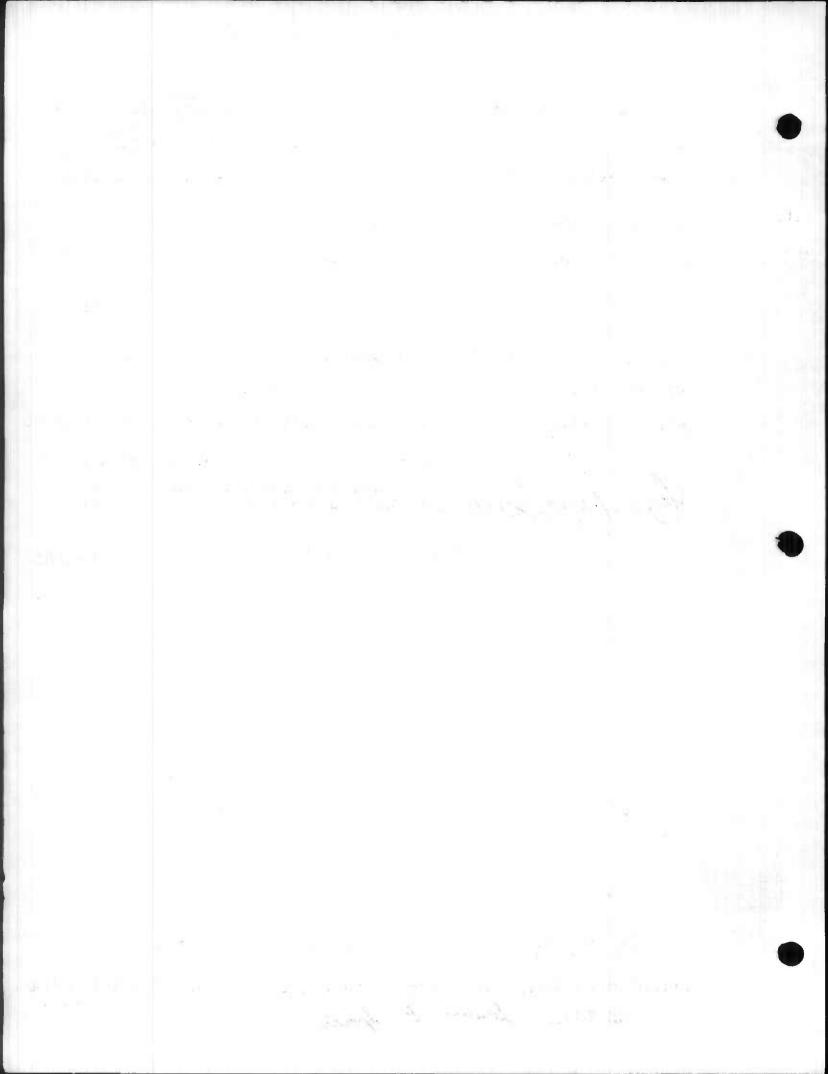
State Registrar one

29b. Signature and title of certifier

Drive, Suite 5, Easton, N 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) 29464 , M.D avia 31. Data filad (Month, Day, Year) 32. Registrar's Signatura JUL 2 4 2000

29c. License number

29d. Date signed (Month, Day, Year) 20/00.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24548 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Month **Physician** ARCHIE BROWN JR 6:45 pm JULY 11 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL CENTER NONE

9. Birthplaca (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 18M 20F Yrs Director 65 SEPT. 25 1934 MARYLAND 216-30-2430 Usual Rasidence of Deceden with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 775 ANNAPOLIS NECK ROAD 21403 USA 2 should be filed within 72 hours efter death on end Mentel Hygiene.

The marked other than "natures", or items 234 Funerai 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 🔯 Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th SELF EMPLOYED REFUSE 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) ARCHIE C. BROWN SR. VIOLA KENT 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Depertment of Health end Important: If item 27 ie m eny injury or other treum DACE. ARCHIE C. BROWN , III (SON) 601 TRIPP CREEK CT. ANNAPOLIS, MD. 21401 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Maurial 2 Cremation 3 Removal from Stata ANNAPOLIS MEM. GARDENS 7/17/00 ANNAPOLIS, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funeral Sarvice Licensee 22. Nama and Address of Fecility Harry D. Leese MO0482 WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast,

Approximately 1. Approximate Interval Batween Onset end Death **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical POSSIBLE MYOCARDIAL INFARCTION 0.5 HOUR Examiner Due to (or as a consequence of): Examiner SEIZURES 1 DAY Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last attending physicien end for use as the burial-tran Due to (or es a consequance of): certificete be execu GLIOBLASTOMA 2,5 MONTHS Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 6 1 | Yes 2 | No 3 | Probably 4 X Unknown DIABETES MELLITUS signed t Records, by 24b. Wara autopsy findings eveilable prior to complation of cause of death? 24a. Was an autopsy Completed Deed page 2 has 2 No 1 ☐ Yas 2 No 1 ☐ Yas of Vital this certificate Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) P 1 Yas 2□ No funeral 27. Mannar of Death 28d. Dascribe how injury occurred Certification: al or Attain.
urs after death.
real Director: After 1 Natural 5 Pending investigation Injury 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place, and dua to the causa(s) end mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b, Signature and title of setting 29c. Licansa number 29d. Data signad (Month, Day, Year)

State Registrar 31. Data filed (Month, Day, Year) JUL 19 2000

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

S. HANOVER ST., BALTIMORE, MD 32. Registrar's Signatura

MD

Russell 21225

DR.

DEA: AS2441614 - A64

JULY

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11, 2000

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State of Maryland / Department of Health and Mental Hygiene 00 24549

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		Felipe Za	arreva -	friend		3890	Davi	la S'	treet	, Da	llas T	X 75	220			
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JUL 20 2000 James of June 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month **Physician** July 15, 2000 3:00 PM Carlos Balbino /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Troyer Road North of Monkton Road Monkton Baltimore 8. Date of Birth (Month, Dey, Yeer) June 11, 1982 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country)
 MEX1CO 6. Sex 1 □ M 2 □ F 7. Age (In yrs. lest birthdey) **Funeral** Deys Months Hours Min. 18 Yrs. Director Unknown Usual Residence of Decedent the Marylend permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic avent, the Medical Example must be notified at once. 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Baltimore White Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2921 Hunter Mills Road 21161 Funeral Mexico 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes, 2 W No If Yes, Give Yeer or Dates: 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 XYes 2 No Specify: Mexican Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Moises Balbino Maria Ramirez 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Felipe Zarreva - friend 3890 Davila Street, Dallas TX 75220 20b. Pleca of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete La Moncada Mpio 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) July 25Tarrimoro Gto, MX Cementerio Municipal 22. Name end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximete intervel Between Onset end Death sused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (opes a consequence of): Examiner attending physician end for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequença of) signed by the a P.0. Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? After this certificata has funerel director, paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifical letely filled in by the funerel director. 25. Wes case referred to medical Be 26. Pleca of Deeth (Check only one) examiner? Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ MOther (Specify) at SCENE Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel Injury 07-15-2000 4:48 1 ☐ Yes 2 ☑ No Passenger in motor vehicle accident 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Troyer Road North of 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 \ Homicide Street Monkton Road, Monkton, Maryland. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Fune completely fil 29a. Certitier edicai and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Taries 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MATIEC Donnel 31. Date filed (Month, Day, Year) 32 Registrer's Signature State JUL 2 0 2000 Registrar

101 20 2000 James 12 18 18 18 18

State of Maryland / Department of Health and Mental Hygiene 00 2455

				Certificate of	Death	Rec	. No.	
		1. Decedent's/Nama (First, Middla, Last)	-	7		2. Deta of Deeth		3. Time of Death
	Physician	MURTIE		3 Rows		July 2	Dey Yaar 0 2000	5:42 PM
	/Medical	4a Facility Name (If not Institution, give stre	et and number)		4b. City, Town, or L		4c. County of Dea	
40	Examiner					1.00		
		Anne Arundel Medic 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthdey) If Under 1 Yaar	Annapolis		Anne Aru	thplece (Steta or Foraign
	Funeral Director	216-82-3950 1 ^{DM}	2K) F 87	Yrs. Months Deys		8. Data of Birth (Month, Dey, Y June 20,	(ear) 1913 Ma	ryland
	pue A	Usuel Residence of Decedent 10e, Stata 10b, County	10c City	Town or Location				10d. Inside City Limits
	efter death with the Maryler or items 23a or 28s-f show miner man be notified at V Funeral Director			napolis				1X Yes 2 No
	rec	10e. Street and Number		10f. Zip Code		100	. Citizen of Whet C	ountry?
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	r tems 23	11. Marital Status 12.	Wes Decedent Evar in U.S.	13. Was Decadent of If Yas, specify Cul		ecity Yas or No-	14. Rece - Am	
21215-0020	within 72 hours effer death with the Maryland see. then "natural", or items 23a or 28e-f ahow he Medical Exercine man be notified at smooth of the Medical Exercine man be notified at smoothed by Funeral Director.		Armed Forces? 1 Yas 2 No If Yes, Give Yeer or Datas:	If Yas, specify Cul		Rican, etc.)	Black, Whi	ta, atc. Thite
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lar	8 2 7 2 W				Sarah 1	Elizabeth	Rollisto	n
Maryland	S D E E	19e. Informent's Neme/Relationship (Type,	Print)	19b. Meiling Address (Stree	t end Number or Rur	el Route Number, (City or Town, State,	Zip Code)
	47 P B B P B B B B B B B B B B B B B B B	Jean Woods / daughte	r	145 Prince G	eorge St.	Annapo	lis, MD.	21401
e,	-155	20a. Method of Disposition		ce of Disposition (Nema of netery, cremetory or other plants			oc. Location - City of	
Baltimore,	00 = 5	1 X Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donetion 5 ☐ Othar (Specify)	Over from State	Lcrest Mem. G	ardens 7-		nnapolis,	
Ball	Depertment Depertment Important: any Injury once.	21. Signeture of Funeral Service Licensee	0 01	22. Name end Addr	ess of FecilityJohn	n M. Tayl	or Funera	1 Home, Inc.
LALI	00500	- Suis	Yould	147 Duke o	f Glouces	ter St.	Annapolis	,MD 21401
		23a. Pert1. Enter the diseese, or complicat shock, or heart feilura. List only one of	ions thet caused the deeth.	Do not enler the mode of dy	ing, such es cardiac	or respiretory erres	t,	Approximate Interval Between
	Physician	anound of mount tomate. East only one	August on cook line.					Onset and Death
	/Medical	Immediate Cause (Final disease or condition	MIPS	unovia				7 11445
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Вох	attendin for use	d						
	the atte	Pert II. Other significant conditions contrib	uting to death but not resulti	ng in the underlying cause g	iven In Pert I.	23b. Did tob	acco use contribut	s to the causs of death?
P.0	to to		Mellitus			1 🗆 Yes	2 No 3 1	Probably 4 Unknown
S	8 55 0			20 (21)		04- 144	24h	. Were autopsy findings
0	The law requires cele has been sign, pege 2 should be					24a. Was an performe		evaileble prior to completion of causa
ec	hes by pe 2 st							of deeth?
E	The le					1 ☐ Yes	200	1 ☐ Yas 2 ☐ No
ita	certificele rector, peg	25. Wes case referred to medical			26. Plece of Deel	h (Check only one))	
of Vital Records,	hyalol his ce il direc	examiner? 1 Yes 2 No	oital: 1 Sepatient 2 EF	R/Outpelient 3 DOA	ther: 4 Nursing Ho	ome 5 Residen	ce 6 ☐Other (Sp	ecify)
0			- 1	8b. Time of 28c. Injury	ury et	28d. Describe how	injury occurred	
0	leath. lor: Aft the fur catio	2 Accident S Pending Investigation	(MORIII, Dey Teal)		Yes 2□No			
Division	to or Attending P is after death. In Director: After the In by the funers Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home building, etc. (Specify)	e, ferm, street, fectory, office		28f. Location (Stre City or Town,		Rurel Route Number,
	Se su lo							
	To the Heapital or Att within 24 hours after d To the Funerel Direct completely filled in by Medical Certiff	29a. Certifier Check only 2 Medical Examiner	On the basis of examinetion	edge, deeth occurred et the to end/or investigation, in my	ime, date end plece, opinion, deeth occur	end due to the cau red et the time, dat	ise(s) end menner e e end plece, end du	es steted. ue to the ceuse(s)
	within 2 To the comple	- AA	and menner steted.	000 1:000	as asset in	200	d Data sissa d Miles	oth Day Vand
	T V V	29b. Signature and the of certifier		29c. Licen	se number	j 290	d. Date signed (Mor	in, Day, Tear)
		Les Mes		UN	133 77	1 1	1/20/0	000
						-	1	
		30. Name end address of person who comp	leted causa of death (Item 2	3e) (Type, Print)	11 11	100.1	CNIT	
		30. Name end address of periods who comp	leted-causa of death (Item 2:	NA ARRIVA	Il N	Wellcar	Cont	2-1

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JUL 2 & 2000

State of Maryland / Department of Health and Mental Hygiene amend item 20b,c per G786 8/2/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Deta of Deeth Month Dey **Physician** Melvin Monroe 29 1:15 pm June 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva street end number) Examiner VA Medical Center, Fort Howard MD 21052 Fort Howard Baltimore 7. Age (In yrs. last birthdey) If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7-17-40 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Deys 1 ₩ 2 F Yrs. 59 215-38-2144 Maryland Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show 77 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examine must be mothed as Rd. Queen Anne 1 Yes 2 No Starr 10952 Queen Anne Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number U.S. 21657 10952 Starr Rd. Funeral 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Meritel Stetus filed within 72 hours after Yes 2 No f Yes, Give 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Black by If Yes, Give Yeer or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 12 Custodian 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fathar's Nema (First, Middle, Last) Be 1 and 2 should be Heelth end Mentel Alice Baker Chas Baker 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth elimportant: If item 27 is any injury or other trau Queen Anne, Md. 21657 10952 Rd. (Wife) Starr Helen Baker 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 7/1/00 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Creamatory Salisbury, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Dashiell Funeral Service 21601 8 Easton, Md. 322 East Ave. 23a. Pert1. Enter the disease, or complications that caused it is deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failure. List only one cause on each line. Approximete Intervet Between Onsat and Death Physician Immediata Causa (Final disaesa or condition resulting in death) /Medical . End Stage Acquired Immune Deficiency Syndrome ll years Examiner Due to (or es e consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata cause. Enter Undarfying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of) pue Box 68760, Physician/Medical the Due to (or es a consequence of) USB 85 signed by the e P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ of Vital Records, 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? pege 2 should Completed 24a. Wes en eutopsy performed? 1□ Yes 2□No 1 ☐ Yes 2 ☒ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ₺ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Mennar of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After Division 5 Pending investigation 1 Naturel efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) in by 4 Homicide within 24 hours of To the Funeral I Hospital 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. Medical 29a Certifier To the 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier June 29, 2000 30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print) 9600 North Point Road, Fort Howard, MD Aurora Tan, M.D.

Registrar

State

31. Data filed (Month, Day, Year)

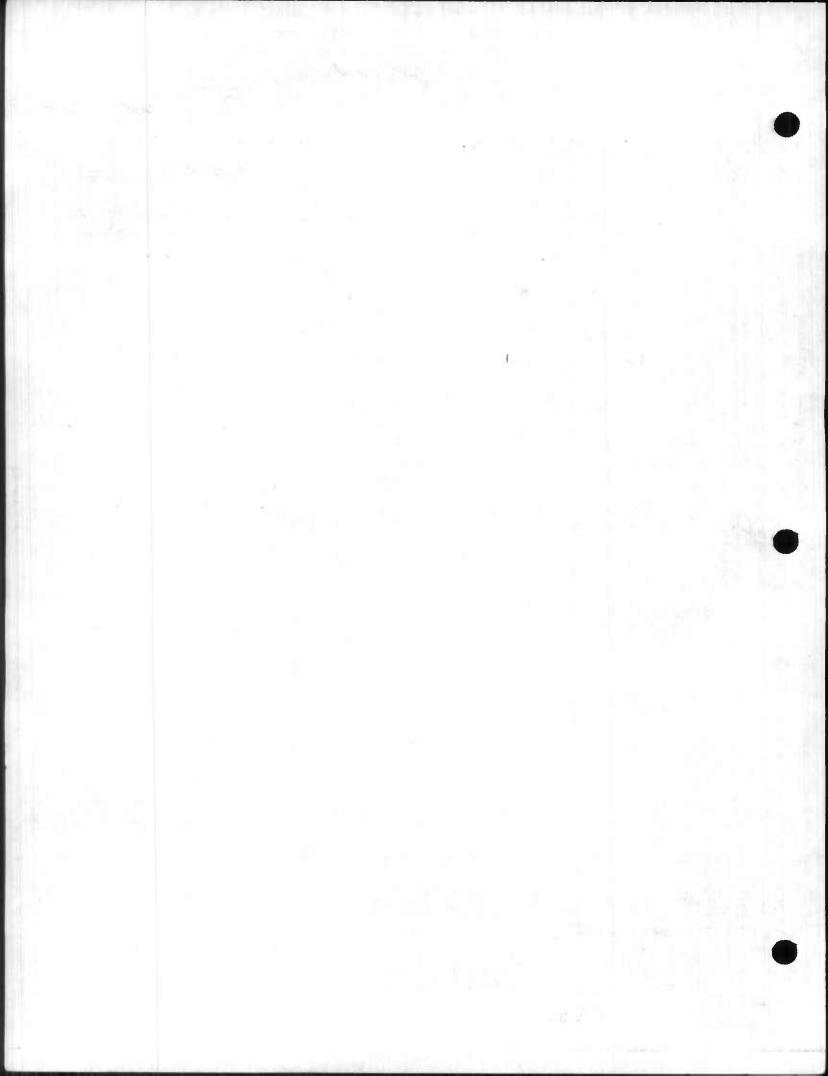
JUL 0 3 2000

DHMH 16 Rev 6/95

AKA: Baker, Melvin M.

SHS

32. Registrer Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23,28a.b.c.d,e,f,per me G786 8/2/00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month TUNE **Physician** 0716 ANTREW PAULO 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Deeth Examiner POTOMAC 12712 STERVE CHASE WAY MONTGOMERCY | Months | Deys | Hours | Min. | 8. Date of Birth (Month, Dey, Year) | Feb. 10, 1 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral №** M 2 F Months 1940 New York Yrs. 60 Director 101-32-3259 Usuel Rasidence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28e-f show N☐ Yes 2 No Maryland Montgomery Potomac Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examination and once. 12712 Steeple Chase Way 20854 S. A. Funeral 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Detes: 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 7 Years Attorney Law 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) David Ball Mabel Jackson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Judith S. Ball - Wife 12712 Steeple Chase Way, Potomac, Maryland 20854 of Disposition (Name of 20b. Plece of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition 6/13/2000 1 N Buriel 2 □ Cremetion 3 □ Removel from State King David Memorial Gardens 4 ☐ Donetion 5 ☐ Other (Specify) Falls Church, Virginia 21. Signature of Funeral Service Licensee Banzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disaasa, or complications that causad the shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Finel disaase or condition resulting in deeth) ASPAYXIATION Examiner Due to (or es e consequence of): Examine HANGIRG Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown WEPRO3510V 9 Division of Vital Records. 90 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Saged 1 Yes 2 No 25. Wes case referred to medical examiner?

1. Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 □Other (Specify) 0 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred hanging 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of Certification: 5 Pending investigation 0716 1 Naturel July 10,2000 1 ☐ Yes 2 🖳 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Flural Route Number, City or Town, Stete) 12712 Steepcoc hoya way Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) or A after Direct 4 Homicide home Potomac Montgomery 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medicat Examinar: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29a. Certifian edical (Check only 77 To the Within 2 To the

State Registrar 31. Dete filed (Month, Day, Year)

29b. Signature end title of certifiar

JUN 14

CARL I. WARGOUS, MD 1125 ROCKVILLE BIKE, ROCKVILLE, MG 20852 32. Registrer's Signature

OME

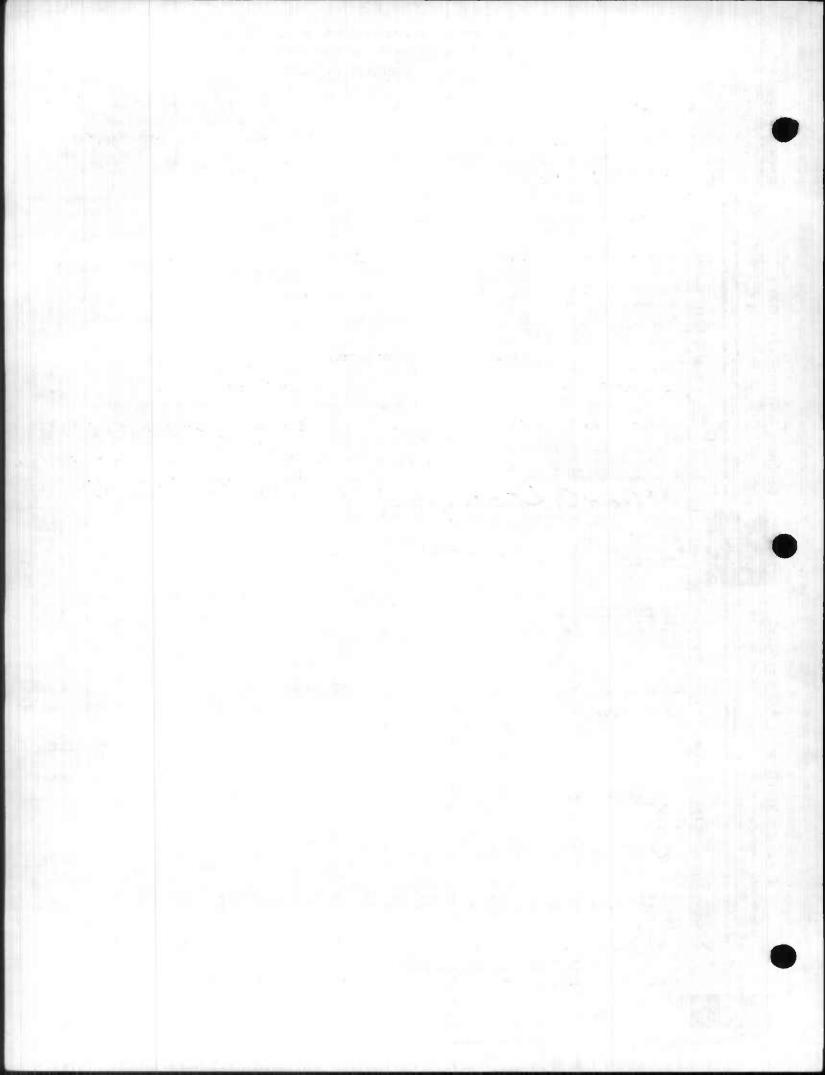
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. Licanse number

015236

29d. Date signed (Month, Dey, Year)

twi 10, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** BELLIE BENEDICT LORRAINE 1014 17 2000 /Medical 20-06 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner HARFORD MEMORIAL HOSP If Under 24 Hrs.
Hours Min. Ot FRALT HAR FORD 9. Birthplece (State or Foreign Country) Maryland If Under 1 Year Months Deys 8. Dete of Birth (Month, Dey, Year) May 29, 1923 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M 2XXF 220-24-4634 72 Director Usuel Residence of Decedent with the Meryland 10a. Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XI¥es 2□No Director Maryland Cecil Perryville 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 611 Susquehanna Avenue 21903 U.S.A. Funeral death 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer o Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinance. 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2XXVo by Specify: 3∑Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Aberdeen Proving Ground College (1-4or 5+) One Year Elementary/Secondery (0-12) Aberdeen, Maryland Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Oscar Roy Evans Elizabeth Eberly 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Darwin E. Benedict (son) 606 Chapel Terrace, Havre de Grace, Maryland 21078 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2/O'Cremetion 3 ☐ Removel from Stete R.A. Ferris & Co., Inc. 7/21/00 West Chester, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service License 22. Name end Address of Fecility Lee A. Patterson & Son Funeral Home, P.A. Noncas M. Tallerson, Sr. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediete Cause (Finel diseese or condition resulting in deeth) /Medical ASCUD Examiner Due to (or es e consequence of): Examiner lew requires thet the death certificete be executed physician and s the buriel-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the ettending I to be detached for use as esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION by 24b. Were autopsy findings evelleble prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? Completed hes 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: P 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Menner of Deeth Certification: 28a. Date of injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end menner as stated.

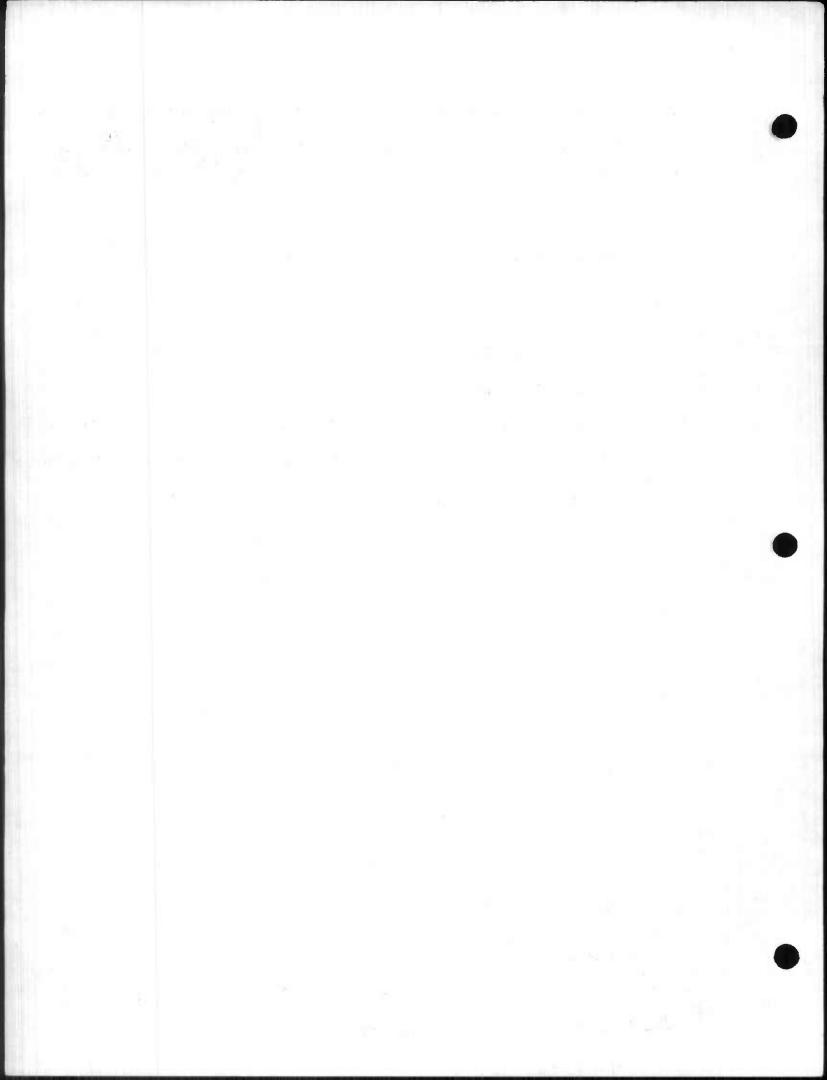
2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a, Cartifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DMA M OCME 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 12 PRABHU M.D. 728 BELAIR NO BELGIR MD 21047

State Registrar

JUL 2 0 2000

31. Dete filed (Month, Day, Yeer)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** Carolyn Dorothy Brooks 18 2000 1250 JUL /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours 1 M 2 XF Yrs. 219-32-6251 63 Director July 27, 1936 Maryland Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yes 2 ₹ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2204 Candice Choice Ct. 72 hours efter death 21015 USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, atc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health end Mental Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 27 is marked of traumatic ev. 2 Conrad (nmn) Kutzberger Iena (nmn) Uhl 19a. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) t: If Itam 27 it William Thomas Brooks / Husband 2204 Candice Choice Ct., Bel Air, MD 21015 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Francis de Sales Cem. 7-21-00 Abingdon, Maryland ajure of Funeral Service 22. Name and Address of Fecility
McComas Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or han failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Batween Onset end Death Physician Immediate Cause (Final disease or condition rasulting in death) /Medical . Respiratory Failure YN Examiner Due to (or as a consequence of):
Idiopathic Pulmonary Filmosis Examiner sician and burlat-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Hypo caemia of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): d for use as t Metabolic Acidosis Dehydration cate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings availabla prior to completion of cause of death? 24a. Was an eutopsy 2000 1 □ Yas 2 □ No 1 Yes this certificate Attanding Physician: the funeral director, 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer Division 1 Natural 5 Pending ie Hospital or Attanding n 24 hours after death. ne Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) end manner steted. 29a. Certifier Medical completely (Check only one) To the Ewithin 2 29b. Signature and triblor certifier 29c. License number 29d. Date signed (Month, Dey, Year) 018424 JULY-18-2000

DHMH 16 Rev 6/95

State Registrar

Brooks, Carolyn

Harford Rel. Fallston MD. 21047.

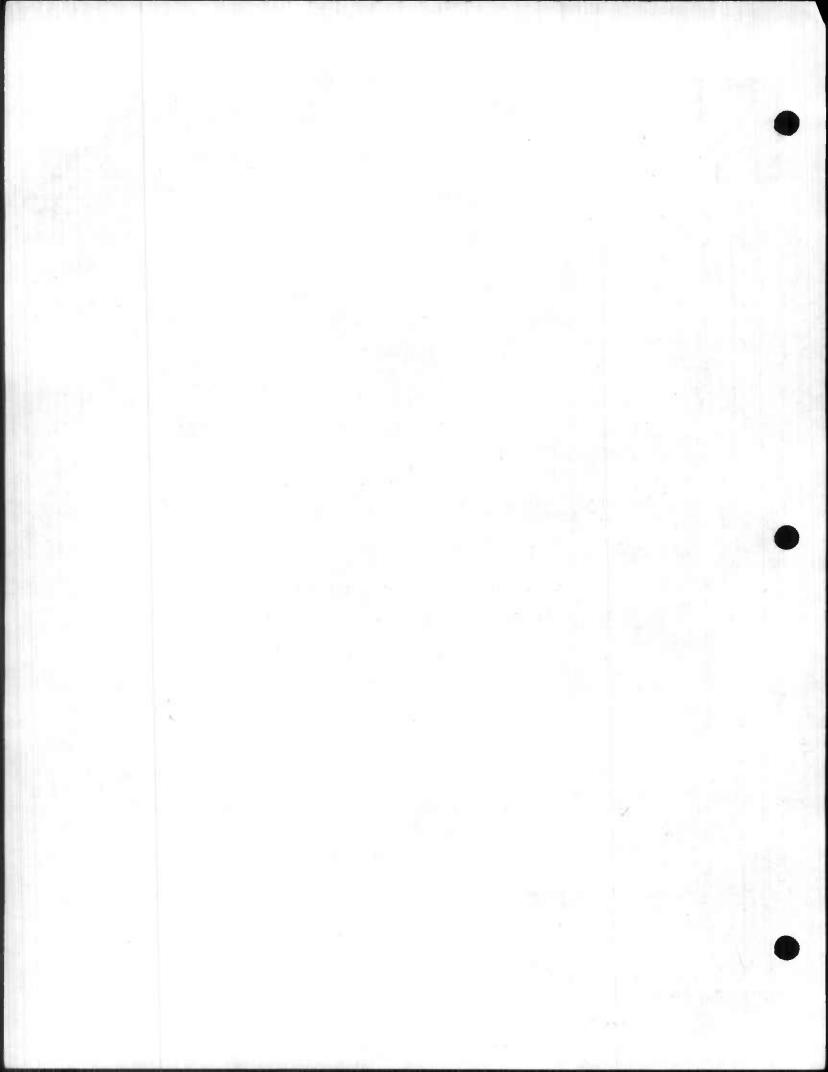
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13. PAREKH MD, 1908 Hayfrul

2 0 2000

31. Dete filed (Month, Day, Year)

1908

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Bishop **Physician** 03: Ohn 19,2000 Julu /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number, Examiner HOPKINS Baltimores If Undar 24 Hrs. 8. Date Johns Hospital If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10 M 2□ F 85 Yrs. Maryland 215-10-5689 28.1914 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 □ No Maryland N/A Director Baltimore 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 1342 James Street U.S.A. 21223 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Datas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify. White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cottege (1-4or 5+) Steamfitter 8th Grade Plumbing permit. Pages 1 and 2 ahould be file.
Department of Health and Merial Hyp.
Important: if item 27 is marked
any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) John Raymond Hilda (Surname Unknown) Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Raylon Dr., Apt. K, Baltimore, MD 21236 Miss Sharon A. Schutz (dghtr) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Ramoval from State 4 Donetion 5 Other (Specify) 7/21/00 Baltimore, Maryland Green Mount Crematory 22. Name and Address of Fecility
Schumuner Funeral Home, Inc. 21. Signeture of Funeral Service Licensee Buin Ce. wellen 9705 Belair Rd., Baltimore, MD Approximate Interval Between Onset and Death 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final 20 day disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner d3case 1915 Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest been signed by the attending physician and should be detached for use es the burial-tran The law requires that the death certificate be exec Box 68760, Dua to (or as e consequence of) P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy 2 No 1 Yes 2 No 1 Yes aptial or Attending Physician: Thours after deeth.

meral Director: After this certificate y filled in by the funeral director, pa Be 25. Was cese referred to medicel 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 28c. Injury at Work? Certification: 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Matural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 16 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number R. ES - 000 2000 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) Jeff 600 N. Wolfe Street Baltimore, Maryland 21287 31. Date filed (Month, Day, ochreiber

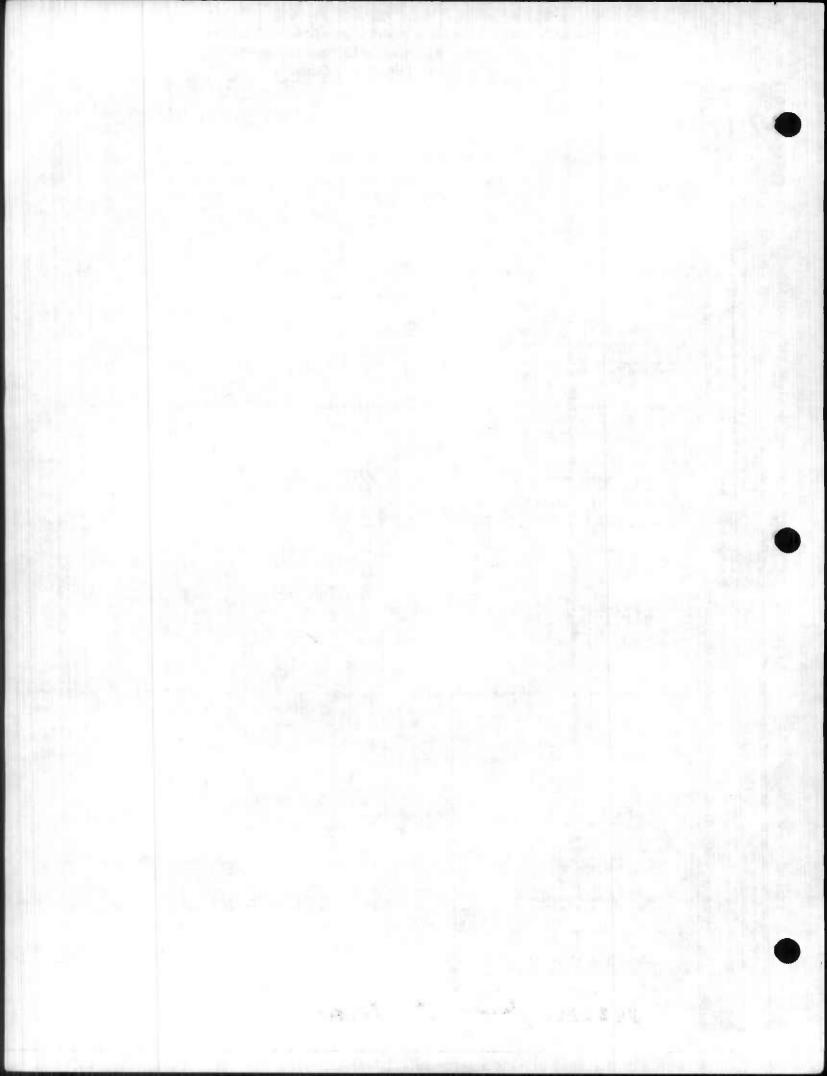
DHMH 16 Rev 6/95

State

Registrar

Registrar's Signatura

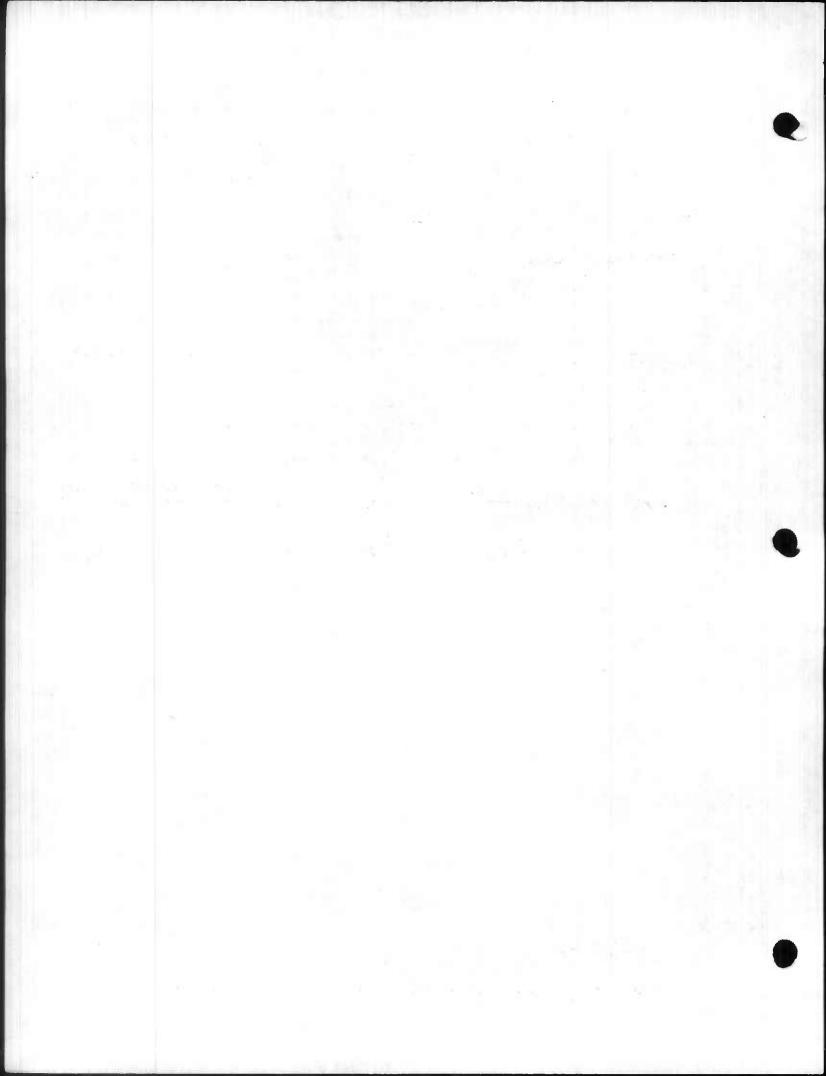
2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth 2. Date of Death Dey 2000 **Physician** JULY 22, PAUL ROGERS COMBS 7:13 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9700 Charles Street La Plata Charles If Under 24 Hrs. If Under 1 Year Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1₽M 2□ F Vre. 240-34-8940 71 Director AUG 16 1928 North Carolina Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits al', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Charles La Plata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9700 Charles Street 20646 USA Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Stetus 72 hours after 1 Never Merried 2 ₩ Merried 1 TYes 2 No WWII r than "natural", or altimore. Maryland 21215-0020 1 Yes 2 No Specify: White Specify p 3 Widowed 4 Divorced Yeer or Detes: Korea Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Meat Cutter Wholesale Food 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Heelth and Mental int: If item 27 is marked or Leslie Combs Nellie Strickland Combs 0 19a. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth of Hem 27 is other tra 9700 Charles Street La Plata, MD 20646 Jessie Marie Combs (wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State = 8 permit. Page Department of Important: If eny Injury or page. Maryland Veterans Cem. 7/25/00 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuderal Service Licensee 22. Name and Address of Facility Eberwein Funeral Services M00173 den 4433 White Pls. La. White Pls., MD 20695 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** ateral sterusis Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. PO signed by th 1 Yes 2 No 3 Probably 4 Unknown Records. p 24b. Were eutopsy findings aveilable prior to Completed 24a. Was an eutopsy completion of cause of death? page 5 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 2 Accident 5 Pending deeth. 1 Yes 2 No investigetion after deeth 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide Hospital or 24 hours after Puneral Difference in Interest Diffe 29e. Certifier 11X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the or Medical To the Hosp within 24 ho To the Fune completely fi (Check only IV: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of our 29c. License number 29d. Date signed (Month, Dey, Year) D 27348 July 24, 2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 700 Old Line Court #100 Waldorf, MD 20602 Howard Haft, M.D. 31. Dete filed (Month, Day, Year)
JUL 2 6 2000 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** CHARLES EDWARD CHANCE 2000 JULY 26, 0615 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Caroline Nursing Home Denton Caroline 8. Deta of Birth (Month, Day, Year) If Under 1 Year If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Deys Hours 1 M 2 □ F 214-28-8003 74 Yrs. Director Sep. 17, 1925 Maryland Usual Rasidance of Dacedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, it.e Medical Examiner maint be notified at 1 TYas 2 No Director Federalsburg MD Caroline 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter deeth v
Department of Health and Mentel Hygiene important: if item 27 is marked other than "natural", or itema 28a any hijury or other traumatic event, the Medical Examples 200.68. 107 Greenridge Road 21632 United States Funeral 12. Wes Dacedant Evar In U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Bleck, Whita, atc. 1√Xes 2 No If Yes, Giva Yeer or Dates: 1 ☐ Navar Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas A ☐ No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Tri-Gas Oil Co. Mechanic 6 18. Mother's Nama (First, Middla, Maidan Surnama) 17. Fether's Nama (First, Middla, Last) Be Harold Chance Lucy Hubbard 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 Greenridge Rd., Federalsburg, MD 21632 Betty W. Chance/Spouse 20b. Place of Disposition (Name of cemetery, crametory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 □XBurial 2 □ Cremation 3 □ Removel from Stete Hill Crest Cemetery 7/28 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licenses 22. Nama and Addrass of Facility Framptom-Hawkins-Eskow Funeral Home, Eskow PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Physician /Medical Immediata Cause (Final disaasa or condition resulting in daath) Examiner Dua to (or as a consequance of) Examiner The lew requires that the death certificate be executed buriei-transit Sequantially list conditions, if eny, leading to immadiata ceuse. Entar Undarlying Cause (Disaese or Injury that initieted avents rasulting in death) Last pue Dua to (or as a consequence of): attending physician Physician/Medical the Due to (or es e consequence of): 89 esn Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Wara autopsy findings evallable prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes 1 ☐ Yas 2 ☐ No 1 Yas 2 No usi or Atten.
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Aurei Director: Affer this centur. 25. Was cesa rafarred to medicel axaminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No ပ္ 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 5 Panding Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida To the Hospital o within 24 hours of To the Funerel Di completely filled in 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mennar stated. 29a. Cartifian Medical (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signatura end titla of certifle

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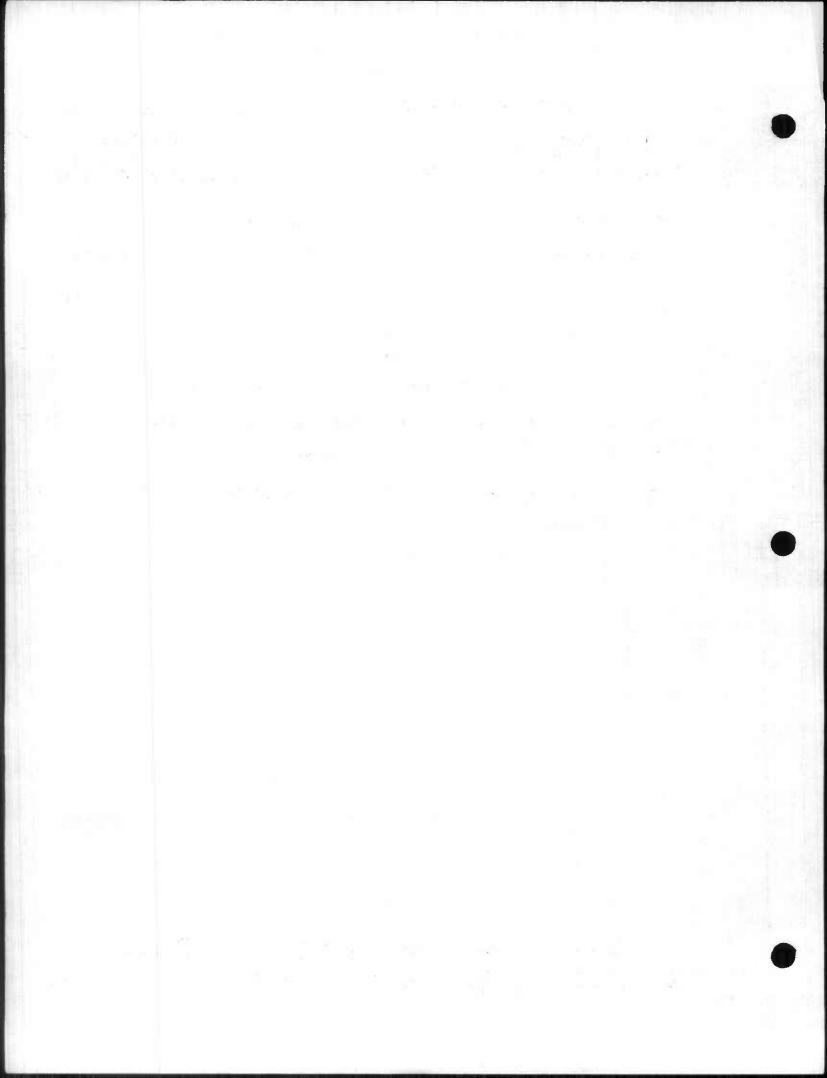
Janca 31. Data filad (Month, Day, Year)

30. Nama and address of person who completed ceusa of daath (Itam 23a) (Type, Print)

9

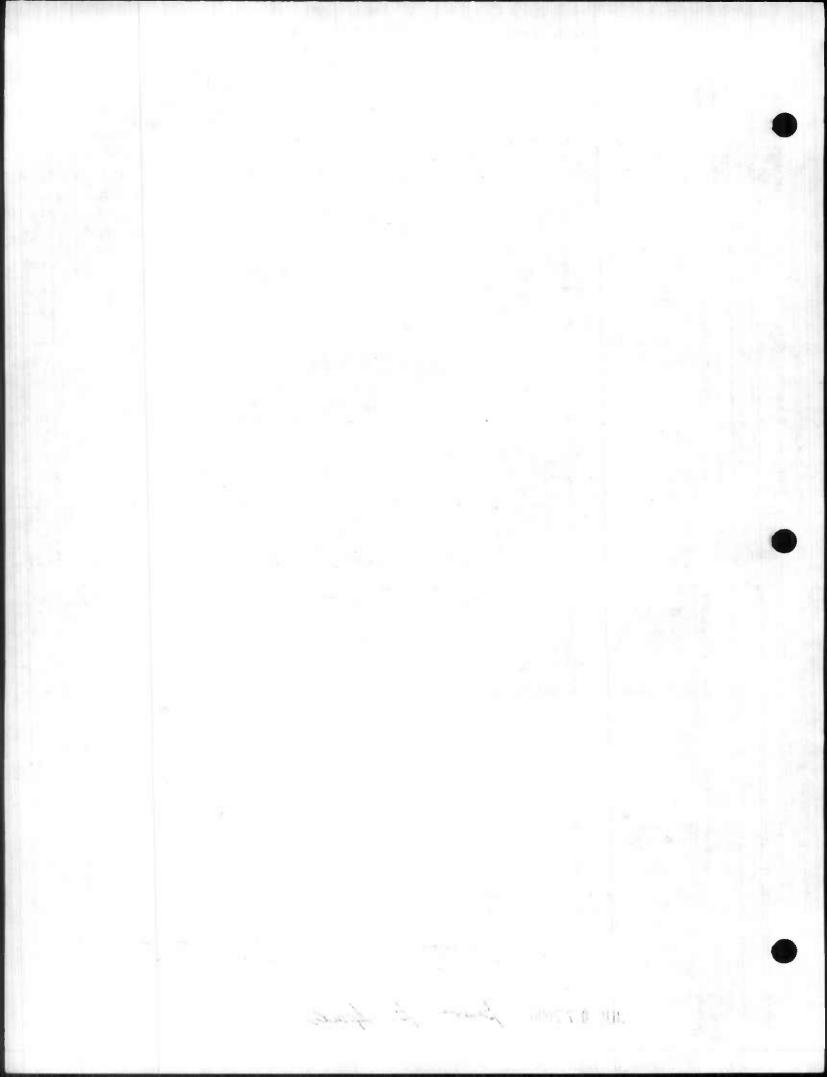
32. Registrar's Signatura

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0. 21, 5, 5, 0

	Certificate of Death	Reg. No.
Physician	1. Decedent's Nama (First, Middle, Last)	2. Deta of Deeth Month Dey Year 3. Time of Death
/Medical	Mary Attaway Carter	July 4, 2000 9:30 AM
Examiner		r Location of Death 4c. County of Death
	23536 Bushwood City Road Bushwoo	od St. Mary's
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 76	
how	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limi
M To Ot	Maryland St. MAry's Bushwood	1 ☐ Yes 2 🕅 I
vith the Ma or 28e-f e be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
13a c	23536 Bushwood City Road 20618	USA
72 hours after death with the Maryland maturelf, or Items 23a or 28e-f ehow diest Erwiner mast se modified at eted by Funeral Director	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Pue 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No	(Specify Yas or No- orto Rican, atc.) 14. Race - American Indian, Black, White, etc. Specify: Black
natural', aira E	15. Decedent's Education 16a. Decedent's Usuel Occupation	16b. Kind of Business/Industry
than the	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade (Give kind of work done during most of wildle. DO NOT use retired) Homemaker	Own Home
tel Hygie d other evant, H		ame (First, Middle, Meiden Surneme)
	Thomas Carter Helen	
2 should be and Mentel a marked o aumatic ev		Rural Route Number, City or Town, Stete, Zip Code)
alth ar		Indian Head, Maryland 20640
Demil. Peges 1 an Department of Heali Important: If Itam 2 any Injury or other anca.	20a. Method of Disposition 1 \overline{M} Burial 2 \overline{\text{Cremetion}} 3 \overline{\text{Removal from Stata}} \ 4 \overline{\text{Donation}} 5 \overline{\text{Other (Specify)}} \ 20b. Place of Disposition (Name of cemetery, cremetory or other place) Sacred heart Cemetery	Dete 20c. Location - City or Town, Stete 7/8/2000 Bushwood, Maryland
deeth certificate be executed o attending physician and of for use as the buriel-transit siclar/Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinations, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ac or respiretory errest, Approximete Intervel Between Onset end Deeth	
	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of dec
e law raquires the has been signed be 2 should be demanded mpleted by		24a. Wes an autopsy performed? 24b. Were eutopsy finding eveilable prior to completion of causa of deeth?
certificate h rector, pege	or W	1 Yes 2 No 1 Yes 2 No
r this certific ral director, TO Be	examiner? Hospital: Other	eeth (Check only one)
To the Funers after death. To the Funeral Director; After this of completaly filled in by the funeral director. Medical Certification: To	27. Manner of Death 27. Manner of Death 3	Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,
ours after ours after ours after ours after ourself ou	building, etc. (Specify) 29a. Certifier 10 Countying Physician: To the best of my knowledge, death occurred at the time, date and place.	City or Town, Stete)
n 24 hours fund pietaly fill	(Check only one) 2 The limit of examination and/or investigation, in my opinion, death occurred of the time, date end place (Check only one)	curred et the time, dete end plece, and due to the cause(s)
Within Comp	29b. Signeture and title contilier 29c. License number 29c. License number	29d. Date signed (Month, Dey, Year) 7 - 5 - 0 - 0 - 0
	30. Name and address of person who completed the of death (New 23a) (Type, Print) James p. Jarboe, MD Hollywood,	Maryland 20636
State		LALYTAIN 20030
Registrar	31. Date filed (Month/Day, Year) 2000 Programs Signature 4. Apartic	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2000 Month **Physician** 3:00 AM June Marie Clifton /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's 20120 Alderman Lane Park Hall If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Yrs. Director 215-22-8113 May 19, 1910 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Maryla must be notified at 1 ☐ Yes 2 No Director Park Hall 28a-f Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or thems 23s or 20667 USA 20120 Alderman Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ◯ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygen Important: If Nem 27 is marked other thu any Injury or other traumetic Shoe Maker Shoe Factory 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Serene Moore Alderman Hannah Elder Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5721 Hoffman Avenue, Philadelphia, Pennsylvania Thelma E. Faison (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Hall True Holiness Cemetery 7/1/2000 Park Hall, Maryland 22. Name and Address of Facility
Mattingley-GArdiner Funeral Home, P.A. 21. Signature of Funeral Service Lie ardener P.O. Box 270, Leonardtown, Maryland 20650 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. \$ detached à 1 Yes 2 Ng 3 Probably 4 Unknown signed to Records, þ 24b. Were autopsy findings available prior to completion of causa of death? been si Completed 24a. Was en eutopsy page 2 s 2 NO 1 Yes 1 Yes 2 No. certificata Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27, Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physiciany o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner; on the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

JUN 3 0 2000

Boyd,

30. Name and address of price

James C.

31. Date filed (Month/Dey, Year)

32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

B. Sparks

CAlifornia, Maryland 20619

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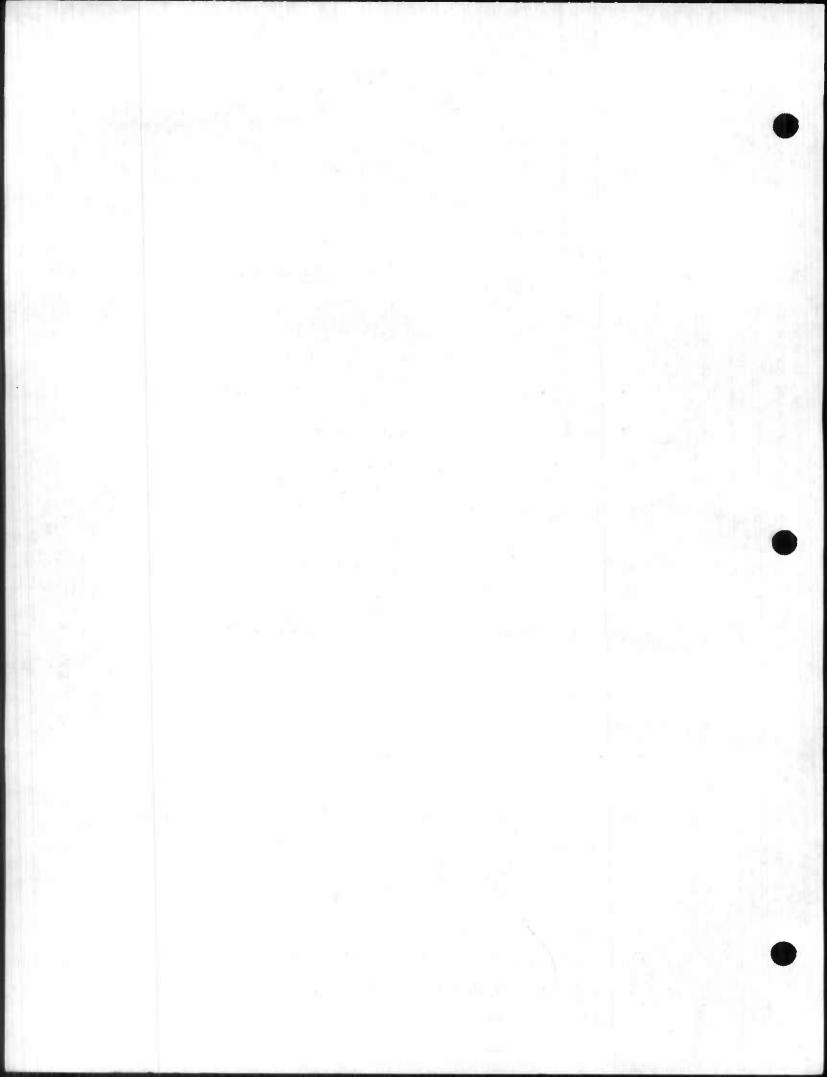
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Cartilla Carrier

State of Maryland / Department of Health and Mental Hygiene

00 24561

-91		Cer	tificate of Death	Reg. No.	
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physiciar	116116166		Jul 22 6	Year 7:15 Pm
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	Examine	Howard County General Hospital			
-			Columbia If Under 1 Year If Under 24 Hrs.		ward
	Funeral	tXIM a∏E	Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country)
	Director	220-48-5918		Aug 14, 1947	Maryland
	pue &	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	eation		10d. Inside City Limits
	oh o				1 ☐ Yes 2 🕱 No
	the Maryler 28s-f ehow nouts at	Maryland Howard Ellico	ott City		
	with the Maryland as or 28a-f show the mounts of the mounts of the country of the	10e. Street and Number	10f. Zip Code	10g. Citizen of	
	th w	4370 Centennial Lane	21042	United	d States
	fler deeth with the Ma	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (S Yes, specify Cuben, Mexican, Puert	pecify Yes or No-	ce - American Indian, ick, White, etc.
0	or h		Yes 2X No Specify:		
5-0020	an Table	3 ☐ Widowed 4 ☐ Divorced Yeer or Dates:	Lifes ZALINO Specify.	Specif	White
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2	should bod Menta		g Address (Street and Number or Ru		State Zin Code)
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	s 1 and 2 should be filed. Health and Mental Hyg tem 27 is marked other other treumatic event,		Centennial Lane		City or Town, Stete
0	ges f of h	20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State	atory or other place)	Dete 20c. Location	City or Town, Stete
E	Peg ant:		's Cemetery 7	7-26-2000 Ellico	ott City, MD
Baltimore	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.	21 Signature of Funeral Service Licensee MDIA44 22	Name and Address of Facility	Davida - Davida	
m	Depa Impo any is		erry H. Witzke's		
		23a Part 1 Enter the disease or complications that caused the death Do not enter	L12 Old Columbia	PIKE EILICOTT (Approximate
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart tailure. List only one cause on each line.	, , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death
	Physician /Medical	Immediate Ceuse (Final	C . 1		2
	Examiner	Immediate Couse (Final disease or condition resulting in death) e. Respirately Spirately Puer to (or as a consequence)	tailure		2 months
		Due to (or as a consequ	uence of):		
	7 ts 6	Cerebral A	Noxia		8 days
	ate be axecuted hysician and the burist-trensit	Sequentially list conditions, Due to (or as a consequence of the conditions)	uenca of):		
00			le Replacen	nent	4 months
68760	ertificate be axecu fing physician and se as the burial-tree	that initiated events Due to (or as e consequence resulting in death) Last			
	as as	Cardiomyop	of the		2 month
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0	deeth e atter	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23b. Did tobacco uae co	ontribute to the cause of death?
0	the ach			1 Yes 2 No	3 Probably 4 Unknown
0	that that deba	Hodgkins Disease treated		10.100	
Records,	The law requires that the deeth cate has been signed by the attendage 2 should be detached for unpage 2 should by Dhuaiclan			24a. Was an autopsy	24b. Were autopsy findings
Ö	need shou	Coronary Artery Diseas	x	performed?	available prior to completion of cause
ec	8 20				ot death?
-	The ate h			1 ☐ Yes 2 12 No	1 ☐ Yes 2 ☐ No
ita/	Physician: The this certificate ral director, pag.		26. Place of De	ath (Check only one)	
7	Physic this ce ral dire	Hospital: 1 Inpatient 2 ER/Outpatient	t 3 DOA Other: 4 Nursing H	Home 5 ☐ Residenca 6 ☐ Ott	her (Specify)
Division of Vital	g Ph er th		28c. Injury at Work?	28d. Describe how injury occu	rred
Ö	ath. Fath	1 □Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No		
15	tal or Attending P is after death. el Director: After t led in by the funera	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	et, factory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
ā	o partie	building, etc. (Specify)		City of Town, State)	
	ours ours fille	29a. Certifier 1 Destifying Physician: To the best of my knowledge, death	occurred at the time, date and piece	a, and due to the cause(s) and m	nanner as stated.
	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page Madical Certification: To Re Comm	(Check only 2 Medical Examiner: On the basis of examinetion end/or inv			
	the of the omple	29b. Signature and little of certifier	29c. License number	29d. Date signi	ed (Month, Day, Year)
0	F 3 F 8	200. Organica card rate of continor		T.)	
		Rita E. Kingma F. A.C.C.	D003715	s Jul,	23,2000
	20	30. Name and address of person who completed cause of deeth (Item 23a) (Type, I	Print)	01	10.00
		Dr. Kita E. King 11085 LiHle	Patrixent P	Kwy Wlumb	19, MD 21041
	State	24 Date filed (Month Day Vend) 20 Benistrade Cinceture 4	land,	/	



State of Maryland / Department of Health and Mental Hygiene 00 24562 Certificate of Death

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South Security Personal State South Security Personal State			4a Facility Name	(If not institution, give	e street and numbe	r)			4b. City, Town, o	or Location of Dea	th 4c. County	of Death	
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Physician //Medical Examiner Immediate Cause (Final resulting in death) Part Due to (or as a consequence of): Due to (or as a consequence of):		20529	10	142				.4/ Duke	of Gloucest	ter St. An	napolis, M	D 2140)1
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Due to (or as a consequence of): Due to		hysician	snock, or naam fallure. Listonly ona causa on aach lina.										Onsat and Death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 24563

		Cer	tificate of	Death		Reg. No.	
Physician (Madian)	Decedent's Name (First, Middle, Last) Anna Lo	ve Bell Con	rnio		2. Dete of Dea Month July		3. Time of Death 6:18AM
/Medical Examiner	4a Facility Name (If not institution, give street end number) ANNE ARUNDEL MEDICAL CENTE			4b. City, Town, or l Annapoli			rundel
uneral irector		(In yrs. lest birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Birth Month, Day	31 ^{Year)} 1931	9. Birthplace (State or Foreig Scotland
H show filed at	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Loc	cation				10d. Inside City Limit
r tems 23s or 28s-fs nips: must be notified Funeral Director	10e. Street and Number 675 Swan Drive		10f. Zip Code 20	751		10g. Citizen of Wi United R	,
by by	11. Merital Status 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 2 2 3 Yes 2 3 Yes 2 3 Yes 3 Ye	No	Vas Decedent of Yes, specify Cut	Hispanic Origin? (Siben, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc.
we then 'natural', it, the Medical Exe Completed by	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or state)	16a. Deced (Give life. L	lent's Usual Occu kind of work done OONOT use retire Mother	ipation a during most of wor ed)	king	16b. Kind of Bus	
B ever	17. Fether's Name (First, Middle, Last) David Alexander Jeffers			18. Mother's Nan Mary Eli		Maiden Sumame)
Important: If item 27 is marke any injury or other traumatic once. To	19a. Informant's Neme/Relationship (Type, Print) Jackie Greitz/Daughter 20a. Method of Disposition 1 Burial 2 Accemation 3 Removal from State	Same	as ite		ral Route Numbe		State, Zip Code) City or Town, Stata
physician and map of important is the burial-trensit and point in portant is the burial-trensit and injury of processing the processing of	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	d the death. Do not enterne.	or the mode of dy uenca of): uenca of): uenca of):	ARRES	nd Road	Edgewate	Approximate Interval Between Onset and Death DAU DAU
s been signed by the attending 2 should be detached for use an pletted by Physician/Me	Part II. Other eignificant conditions contributing to death b			iven in Part I.	1 🗆 `		tribute to the cause of death 3 Probably 4 Uptoo 24b. Were autopsy finding available prior to completion of cause of death?
rector, page rector, page	25. Was case referred to medical			26. Place of Dea	1 □ 1		1 D 2 No
00	examiner? 1 Yes 2 No Hospital: 1 Speatic 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Inju	ther: 4 Nursing H	ome 5 Resid	dence 8 Othe	1-7 77
val Director: After tilled in by the funeral	4 Homicide building, et	ury - At home, farm, stre c. (Specify)			City or Tov	vn, State)	r or Rurel Route Number,
To the Funeral Director: After th completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physicien: To the best 2 Medical Examiner: On the basis on and magner st. 29b. Signature and the of certifier	examination and/or inv	estigation, in my		rred at the time,	date and placa, a	(Month, Day, Year)
	11/14- 1/1		DV.	12777	7	///	111000
	30. Name and address of person who completed cause of c	leath (Item 23a) (Type, I	Print)	1 N/14 Pa	1 Mec	hot I	6.10

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Mary Ti. Crookham July 2000 22, 0807 A /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (ff not institution, give street and number) 4c. County of Deeth Examiner Union Hospital Elkton If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (fn yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Hours Min 1□M 25 F Yrs. 215-32-6021 Sept 22, 1933 Director 66 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Delaware New Castle Newark 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 526 Sparrow Court 19702 Funeral United States death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Meritel Stetus filed within 72 hours efter 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1₺ Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Automotive Elementery/Secondery (0-12) College (1-4or 5+) deck person/production control Manufacturing permit. Pages 1 and 2 should be filed w Depertment of Health and Mentel Hygies Important: if them 27 te marked other th any Injury or other traumatic event, in-poice. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be John W. Crookham Sophia E. Zinger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Brown/Sister 114 Thomson Drive, Elkton, Maryland 21921 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 7/25/00 1 Buriel 2 □ Cremetion 3 □ Removel from Stete Cherry Hill, Maryland Cherry Hill Methodist Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility Hicks Home for Funerals, P.A. 21921 103 W. Stockton St., Elkton, MD el 100 u Approximete Interval Between Onset end Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Septic Shock 24 HRS Examiner Due to (or as e consequence of): Examine Pneumonia requires that the death certificate be axecuted sician end burial-trans Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Bone Marrow Suppression attending physician I for use es the buria 68760 Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequence of) Chemotherapy Box signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 TUnknown Non-Hodgkins Lymphoma of Vital Records. Be Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed' eged 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Neturel deeth. 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dale end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end/namer steted. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier D44102 20 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) William Renzulli, M.D. 901 Warburton Road, Elkton, MD 31. Dete filed (Month, D 2 5 2000 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene

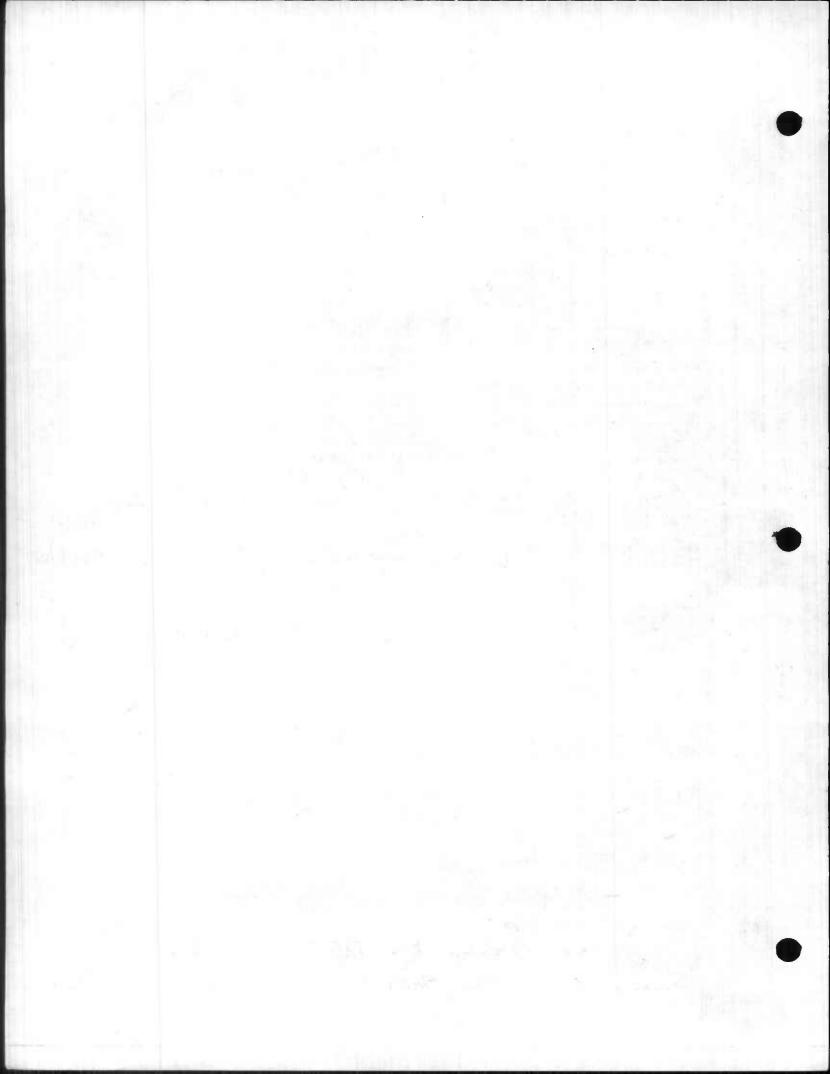
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		Certificate of Death	Reg. No.
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Physiciar /Medica	ELETCHEN V CHUNCH	Duly	17 2000 (0:45 PM
Examine	An English have a Miller that the standard and a combant	4b. City, Town, or Location of Death	4c. County of Death
(4)	Mariner Health of Bel Air	Bel Air	Harford
Funeral Director	5. Social Security Number 217-22-6377 Usual Residence of Decedent	Ast birthday) Yrs. If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 8. Date of Birthday, Min. Month, Day Aug. 2	9, 1916 North Carolina
2 24		, Town or Location	10d. Inside City Limits
A sh	Maryland Harford Bel	Air	1∭ Yes 2□ No
1 the	Maryland Harford Bel 10e. Street and Number		10g. Citizen of What Country?
		21014	U.S.A.
Geen dear	11. Merital Status 12. Wes Decedent Ever in U.S	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indien,
020	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:	Block, White, etc. Specify: White
5-0 Transmer	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade 17. Father's Name (First, Middle, Last) John C. Chwrch	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
22	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
S Sand	10th grade	Leather Cutter	Shoe Company
OL STREET	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)
The state of the s		Jennie Fender	
Man S and T la m	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number	
- 5495	Viola R. Church (Wife) 20a. Method of Disposition 20b. Pl	1310 Churchville Road, Bel	AUL, MD 21014 20c. Location - City or Town, Stete
altimore, mit. Pages 1 a purment of Hes contant if them y Injury or other	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from State	emetery, cremetory or other plece)	
Itin		Air Memorial Gardens 7/21/00	Bel Air, Maryland
Ba Depa mapo	21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the ceath shock, or heart fellure. List only one cause on eachyline.	Schimunek Funeral Home of 610 W. MacPhail Road, Bel	Bel Air, Inc. Air. MD 21014
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Lewers des des des des des des des des des de	Onset end Deeth AR O (4 PAINS)
rifficate being physicia	if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	as a consequence of):	
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of Vital Records, Physicien: The law requires that this certificate has been signed brial director, page 2 should be determed by Pic. To Re Completed by Pic.			an eutopsy med? 24b. Were eutopsy findings available prior to completion of cause of death?
The law		10)	
Vital Indicate The centificate rector, page Co.			
Of Vita Physicien: this certific ral director.	O 1 Yes 2 No Hospital: 1 I lengtical 2 15	26. Place of Death (Check only only of Death (Check only only of Death (
Phys oral d		28b. Time of 28c. Injury et 28d. Describe t	now injury occurred
Attending F redeath. ector: After by the funer	1. Netural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Work? 1 Yes 2 No	
Division alor Attending safter death. I Director: After d in by the fune	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)		Street and Number or Rural Route Number, vn, Stete)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funeral Medical Certification:	29e. Cartifier (Check only one) 29 Medical Examiner: On the basis of examination and manner steted.	viedge, deeth occurred et the time, date end place, end due to the on and/or investigation, in my opinion, deeth occurred at the time,	cause(s) and menner as stated. date end place, and due to the cause(s)
Within To the Comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	114	D28136	7-18-00
10	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	OAn MA
State Registrar	811 2.0 2000	B. South	

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State of Maryland / Department of Health and Mental Hygiene 0 0 24566

			Cert	ificate of	Death	R	leg. No.	6	1000	
Physician	1. Decedent's Nama (First, Middle, Last					2. Dete of Dee _ Month	Day	Voor	3. Time of Death	
/Medical	Isabel Agnes	Downing				July	26 ^{ey} 200	00	6:35p.m.	
Examiner	4e Facility Name (If not institution, give				4b. City, Town, or		4c. County	of Death		
	Caroline Nursing		4	Denton, Maryla			Carol			
Funeral Director		х Эм ж 83	s. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day Dec - 9,	Year) 1916	9. Birthplai Country	(State or Foreign Md •	
P	Usuel Residence of Decedent 10a. Stete 10b. County	10c C	City, Town or Loca	ation				100	I. Inside City Limits	
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er death with the Maryle there 23e or 28e-f sho ner must be notified at uneral Director	10e. Street and Number 1320 Market S	treet		10f. Zip Code 2 1 6	29	1	0g. Citizen of W USA		n	
Mary jiana 212.15-0020 d 2 should be fled within 72 hours after death vin and Mental Hygiana 72 hours after death vin and Mental Hygiana 1997 is marked other than "natural; or learns 23 traumatic event, the Medical Examiner mant To Be Completed by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Detas:		as Decedent of Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Bleci	- American k, White, at Cauc		
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Spiene Spiene North Man It the Men	Elementary/Secondery (0-12)	College (1-4or 5+)	Salesp		during most of worded)		Cloth	ing		
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To To			1							
7 Is of 17 I	19e. Informent's Neme/Reletionship (7) George A. Downi				t and Number or Ru					
- 5 5 6 5	20e. Method of Disposition		Place of Disposi		et St.,		Mary.			
mit. Pages 1:4 partment of He portent: If Hem y Injury or oth	1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Removel from State	cemetery, crema	atory or other pla	ory	7/27/	Dover	1		
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Physician /Medical Examiner	shock, or heert fellure. List only of Immediate Cause (Finel disease or condition resulting in death)	Low	or as a conseque	and	cer	or respiretory arr	031,		pproximate itervel Between baset and Deeth	
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this aidi	1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	iry at ork?	lome 5 Reside				
To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After toompletely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, stree]Yes 2□No	28f. Location (Si City or Town		er or Rural I	Route Number,	
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within 2 comple	29b. Signeture and title of certifier	00		29c. Licen	sa number	2	9d. Date signed	(Month, De	y, Year)	
F > F 0) James	Sixles	-145	D3	1376		7-27-0	00		
	30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type, Pr	rint)	St	ente	on M	2	21620	
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Sign		. Spa	elst.				1	



State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificat	e of	Death			Reg. No.	0 (- 40	0/			
Physician /Medical	١	1. Decedant's Nema (First, Middla, La	oLI\	/E B. D	ONALI	os				2. Data of Date Month	ath Day	Yaar 2000	3. Tima	of Death			
Examiner	-	4a. Facility Nama (If not institution, giv		wor				Princ	vn, or Lo	Anne	ion of Death 4c. County of Death						
Funeral Director			ax / □ M 2 X F	7. Age (In yrs. las 76	st birthday) Yrs.	If Undar Months	1 Yaar Days		24 Hrs. Min.	8. Data of Birt (Month, Day Sept.	h y, Yaar) 23,1923	9. Birthp Cour Ma	eleca (Stata etry) rylar				
with the Maryland a or 28a-f show be notified at		10a. State 10b. County Maryland Somer	set		Town or Lo							1	0d. Inside (City Limit			
th with the Ma 23s or 28s-fs cat be notified	9 0	10e. Street and Number 23190 Paul Ben	ton Cir	ccle		10f. Zip		821			10g. Citizan of V	What Cour	ntry?				
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Physician /Medical Examiner				Ir d ra	Immediata Causa (Final disaase or condition rasulting in death)	a. En	& Stag	g_ (ce.		4			ian		Onset and	
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Physician: this certific ral director. To Be).	1 Yes 25€No	Hospital: 1	Inpatiant 2 EF	R/Outpatier	nt 3 DC	OA Ot	har: 4 Nur	sing Hor	me 5 Rasid	lanca 6 🗆 Oth	er (Specify	1)				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 12 per fh G786 8/24/00 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JULY 22, ^{Dey}2000 **Physician** 10:40 AM HELEN P. DIZE /Medical 4b. City, Town, or Locetion of Death 4a. Facility Nama (If not institution, giva straat and numbar, 4c. County of Death Examiner E. W. McCready Memorial Hospital Crisfield Somerset If Under 1 Year Months Deys 5. Social Sacurity Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Funeral 9. Birthplace (Stete or Foreign 15, 1915 Pennsylvania 1□M 21 F Hours 150-09-8952 85 February Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow Somerset Crisfield Maryland "netural", or items 23e or 28e-f al-adical Examiner must be notified. Director Yas 2 No the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 Cove Street 21817 U.S.A. Funeral 12. Was Decadant Evar in U.S. Armed Forces? world 1 ⊠ Yes 2 □ No war II If Yes, Give Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify by 3KWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 City of Crisfield Secretary vent of Health end Mentai H, It: If item 27 is marked other y or other tree 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Peges 1 end 2 should be Clarence Henry Keiser Ellen Drucilla Payne 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Typa, Print) Patti Lynn Potterton (Daughter) 7 Cove Street - Crisfield, MD 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete cremetory or other place 1 ☐ Burial 2X Cremetion 3 ☐ Ramoval from Stata permit. Pege Depertment of Important: If any Injury or once. Salisbury Crematory 7/24/00 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Punetal Service License 22. Name end Address of Fecility Bradshaw & Sons Funeral Home Kelica N 306 W. Main St.- Crisfield, MD Robert H. Bradshaw, Jr. 21817 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner be executed Sequentially list conditions, if any, laading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest pue -tren physician e 68760 Physician/Medical Due to (or as a consequenca of) The law requires that the death certificete attending p 88 Box P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 3 Probably 4. Unknown 1 Yes 2 No þ Records. page 2 should b 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate of Vital 25. Wes cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No cours effer death.

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*in by the funeral dir 1 Inpatient 2 ER/Outpetient 3 DOA Certification: 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Division Naturel 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital To the Hospital within 24 hours e To the Funeral Completely filled edicai 29a. Certifier 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end manner es stated.
2 Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et tha time, data and place, end due to the ceuse(s) and menner stated. 29b. Signature and title of Dar 29c. License number 29d. Date signed (Month, Dey, Year) D 54422 July 22, 2000 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Sarad Baral, M.D. - 201 HAll Highway - Crisfield, MD

32. Registrar's Signature

DHMH 16 Rev 6/95

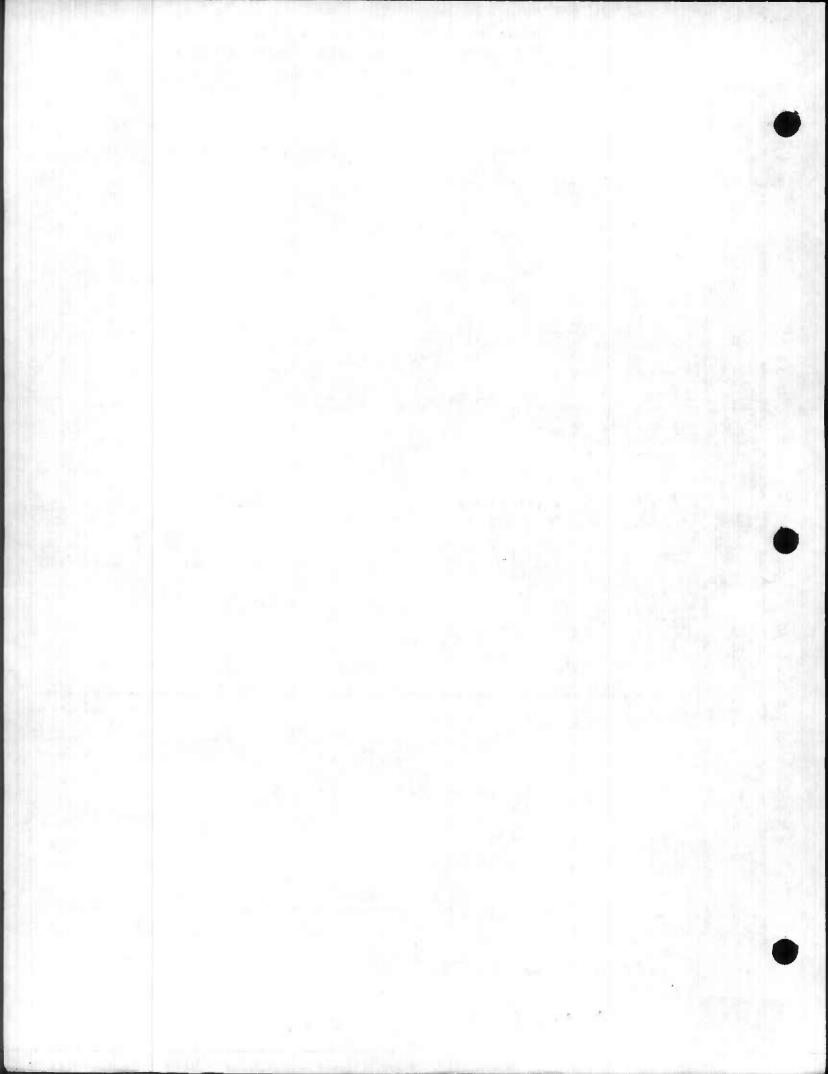
State Registrar 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 00 24569

			Cer	tificate o	f Death		Reg. No.		
	1. Decedent's Neme (First, Middle,	Last)				2. Dete of De	eth	Vaca	3. Time of Deeth
Physician (Madieal	Antoinett	e DiGiacomo				July 2	0, 2000	Yeer	8:30 PM
/Medical Examiner	4e Facility Neme (If not institution, g	give street end number)			4b. City, Town,	or Location of Death	-	of Deeth	
Funeral	Montgomery Vill 5. Social Security Number 6 188-09-4162	age Care & Reha			ar If Under 24	Vin. (Month, De	th y, Year)	Country	ca (Stete or Foreig
Director	Usuel Residence of Decedent	04				Aug. 2	, 1915	Penns	ylvania
f show	10a. Stete 10b. County Maryland Montgor		ity. Town or Lo			WAS S		100	d. Inside City Limit
fire deeth with the Meryland r flerns 23s or 28s-f show free must be notthled at Funeral Director	10e. Streef end Number		elmante	10f. Zip Code	20876		10g. Citizen of W		
s 23	23530 Kings Vall	12. Wes Decedent Ever in U	16 12 1	Man Department of		2 (Specify Ves or No		U.S.A	
urs after alf, or he by Ful	1 ☐ Never Merried 2 ☐ Married	Armed Forces?		f Yes, specify C		? (Specify Yes or No Juerto Rican, etc.)	Specify.	k, White, et	tc.
n 72 hours natural', not call Eu-	15. Decedent's		16e. Deced	dent's Usuel Occ	upetion	Lundrine	16b. Kind of Bu	siness/Indu	istry
s '. s ' 5	(Specify only highest (Secondary (0-12))	College (1-4or 5+)	life. I	maker	ne during most of ired)	working	Ow	n Hom	ne.
el Hygie l'other vent, b	17. Fether's Neme (First, Middle, La	st)			18. Mother's	Neme (First, Middle			
Mental H Mental H Marked off Marked off	Daniel Durant	9			Ange	lia Nia	010		
and Mente and Me	19a. Informent's Neme/Reletionship		19b Mailir	na Address (Stre		lia Nic or Rural Route Numb		Stete, Zio C	20de) 20076
ges 1 end 2 should be filed with t of Health and Mentel Hygiene. If flam 27 is marked other than or other traumatic avent, the M To Be Comp	Ann Kitterman -	Daughter	2353			Road, Ge		, Mar	yland
permit. Pages to Depertment of Himportant: If its any Injury or of price.	20e. Method of Disposition 1 Burial 2 Ocremetion 3 4 Donation 5 Other (Spe	☐Removal from State	cemetery, cren	natory or other p		Defe m 7/22/00			
permit. Page Depertment of important: If any injury or pace.	21. Signature of Fune at Service Lic	Williams) 0:		Moleswor	th P.A.,			20872-0
Physician	23a. Pert1. The the disease, or co shock, or that feilure. List or	emplications that caused the deeply one cause on each line.	th. Do not enf	er the mode of o	lying, such es ca	rdiac or respiratory e	rrest,	1	Approximete Intervel Between Onset end Death
/Medical Examiner	Immediate Cause (Fine) disease or condition resulting In deeth)	Cardiovaso	cular D					1	10 Years
je le			1111-000					i	10 Years
an end riel-transit	Sequentially list condifices, if eny, leeding to immediate cause. Enter Underlying	b. <u>Diabetes M</u>	or es e conseq					1	TO TEALS
death certificate be executed e ettanding physician end of for use as the buriel-transit ician/Medical Examir	that initiated events resulting in death) Lest	C. Due to (or es e conseq	uence of):					
death ce ettandii d for use	Pert II. Other significant conditions	contributing to death but not re	culting in the u	nderlying cause	Given in Pert I	23b Did	tohacco use cor	ntribute to 1	the cause of deat
d by th	Total agricultura	contributing to death but not re-	suiting in the u	ndenying cause	given in reign.				ably 4 💢 Unkno
been sign should be						24a. Wes	en eutopsy omed?	com	re eutopsy findings lable prior fo apletion of cause eeth?
The law page 2	TO A TOTAL OF					10	Yes 2 No	10	Yes 217 No
iffical	25. Wes case referred to medical				26 Place of	Deeth (Check only			-A
sicien certifi irector	exeminer?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpetier	nt 3 DOA	0.1	ing Home 5□ Resi		or /Specify/	
ding Physician: h. After this certific funeral director, tion: To Be	27. Menner of Deeth 1 Daneturel 5 Pending 2 Accident Investiget	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	1 28c. Ir	ANZ IAGISI	28d. Describe	how injury occurr		
To the Hospital or Attanding Physician: The Inwithin 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could no determine	be One Blace of Leive And		eet, factory, offic	ca .	28f. Location (City or To	Street and Numb wn, Stete)	er or Rurel	Route Number,
Ne Hospital n 24 hours ne Funeral pletely filled edical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kni aminer: On the basis of examine and menner steted.	owledge, deeth etion end/or inv	occurred et the vestigetion, in m	time, date end p y opinion, death	pleca, end due to the occurred et the time,	ceuse(s) end me date end pleca, o	nner es ste end due to t	ited. the ceuse(s)
within 2 To the comple	29b. Signefure and title of cartifier			29c. Lice	ense number		29d. Date signed	d (Month, D	lay, Year)
- 5 - 0	1		0) n/4	1931		T11 1++ 2	2 20	00
	20 Nome of distance	o completed acres of days for	- 0261 (7	2	1731		July 2	2, 20	00
	30. Neme end eddress of person wh								
	R. Shumacker, N			Road,	Wheaton	, Marylan	20902		
State	31. Defe filed (Month, Dey, Year)	4 2000 A	ature	~ L	1				
Registrar	JUL Z	7 (1101) P (600)			Married Holl				



State of Maryland / Department of Health and Mental Hygier

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No		1,400			

209.101				Certificate of	f Death	R	eg. No.	0 600	7010
D	1. Decedent'a Name (First, Middle, Las	st)		PER SE		2. Date of Deat Month	h Day	Yaar 3	. Time of Death
Physician /Medical	Thomas Franc	cis Degr	nan			July			8:25 P.M.
Examiner	4a Facility Name (If not institution, give	e street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
	141 Northway				Severna			rundel	
neral ector	047-28-7935	ax 7. Age (h ⊠M 2□F	64 Yr	Months Day		8. Date of Birth (Month, Day) Aug 20	, Year) 935	9. Birthplace Country) Conn	ecticut
	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Legation				104	Inside City Limits
d at	MD Anne A			a Park					1 ☐ Yes 2♥ No
Director		runder	severn						
	10a. Street and Number 141 Northway			10f. Zip Code	21146		0g. Citizen of W	Vhat Country?	
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedanf Eva Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1958- 1968	13. Was Decadent of If Yas, specify Cu	Hispanic Origin? (S) ban, Mexican, Puerto o Specify:	pecify Yas or No- p Rican, etc.)		e - American I k, White, etc. Wh	ite
nt, the Medical Completed	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)	flucation da complated) College (1-4or 5+)	(6		upation e during most of wor red)	king	16b. Kind of Bu		
C H		5+	E	ngineer	1				ar ch
Be Be	17. Fathar's Nama (First, Middla, Last)		C		1000000	ne (First, Middle, I			
10	Thomas Franc				Bernad		Barthol		
recu	19a. Informant's Name/Relationship (Marianne W. I				et and Number or Ru ay, Seve			2114	
	20a. Method of Disposition			isposition (Name of			20c. Location ·		
ury or o	1 Burial 2 Stremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery,	o Crematory or other p	ory	uly 1/	Baltim		
DUCE	21. Signature of Adheral Service Licen	isee			& Sons, P.				
	23a Payl . Enter the disease, or com	plications that caused the	daath. Do no	495 GOV.	Ritchie Ho	or respiratory arr	erna Par	. Ap	21146 proximate erval Between
cian dical hiner Examiner	Immediata Cause (Final disease or condition resulting in death)	b	olfiple to (or as a co		VVIES				
licai	Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	c	to (or as a co	nsequence of):					
-		d							
ed for use	Part II. Other significant conditions of	ontributing to death but n	ot resulting in t	ha underlying cause	given in Part I.	23b. Did to	bacco uae cor	ntribute to the	e cause of death?
e detached y Physi						1 🗆 Y	es 2000	3 Probab	ly 4 🗆 Unknown
page 2 should be d			L			24a. Was a perform	n autopsy med?	availal	autopsy findings ble prior to letion of cause
mp mp							/	of dea	,
Com						124	es 2 No	197	es 2 No
rector, pa	25. Was case referred to medical examiner?	Hospital:		10	9.4	th (Check only or			
F	1 X Yes 2 No 27. Menner of Death	1 ☐ Inpatient	2 ER/Outp	atient 3LI DOA	4 LI Nursing H	oma 5 Reside	enca 6x10th	er (Specify)	at scene Li Fell off ENK SAWW
pletely filled in by the funers	1 Natural 5 Pending investigation 3 Suicide 4 Homicide	7/13/60	At home, falm	iry W	Yes 2 No	LADDER V FELL ON I 28f. Location (S City or Town	HEN TRE	FLIMBH THE L.	END SAWW. ADDER Dute Number,
e din		in you	1 4-	Lone		SEV	IERNIA	PARK	mX
completely filled in Medical Cert	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Example 1	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/	death occurred at the or investigation, in my	time, date and place y opinion, death occu	, and due to the c	ause(s) and ma	anner as state	ď.
To the Funeral Director: A completely filled in by the f	29b. Signature and title of contiller	1		29c. Lice	nse number	2	9d. Date signe	d (Month, Day	/, Year)
=		16 nt	Mip.	0.	C.M.E.		July 14	, 2000	
	30. Name and address of person who	completed cause of death	(Item 23a) (T		treet, Ba	l+imov	Maxv1	nd 212	0.1
State	31. Dafa filad (Month, Day, Year)	32. Registrar's	Signatura	1 1	A h	chilote,	HOTATO	uu 2120	J.L

State

Registrar

JUL 1 8 2000

			State of Maryla	nd / Department of Certificate		ental Hygien		24571
	Physicia /Medica		e, Last)	DINIS		July 1	ay Year Year	3. Time of Death 0 4 00
-	Examine Funeral Director	4a Facility Name (If not institution 5. Social Security Number	12 ARUNDEL	MED CTR s. last birthday) H Under 1 Yrs. Months D	ays Hours Min.	Date of Birth (Month, Day, Year		ARUMEZ ace (State or Foreign y)
20	tould be filed within 72 hours after death with the Meryland I Mental Hygiene. Tarked other than "natural", or frems 23a or 28a-f show matic event, the Medical Extrafore must be redused.	Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE 10e. Street and Number 217 GARDEN GA 11. Marital Status 1 Never Married 3 Widowed 4 Divorced	ATE LANE 12. Was Decedent Ever in Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	U.S. 13. Was Decedent	de 1403 of Hispanic Origin? (Spec Cuban, Mexican, Puerto Ri	10g. C		d. Inside City Limits 1 Yes 2 No n Indian, tc.
Baltimore, Maryland 21215-0020		15. Decedent (Specify only highes Elementery/Secondary (0-12) 12th 17. Father's Neme (First, Middle, GARFIE	College (1-4or 5+) O Last) CLD ANDERSON	NURSING A	one during most of working atired) SSISTANT 18. Mother's Name (CO CA First, Middle, Maide	n Sumame) N	NE HEALT
	permit. Pages 1 end 2 sh Department of Health and Important: if frem 27 ia m any Injury or other treum pnce.	19a. Informant's Neme/Relations MARVIN I)AVIS 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I	(SON) 3 □ Removal from State Molicensee	Place of Disposition (Name cometery, crematory or other DSES CEMETE) 22. Name and A WM. REI	of place) RY 7/ ddress of Facility ESE & SONS	ANNAPOL Dete 20c. I	IS, MD. Location - City or Tow RURY, MA Y, P.A.	21403 m, State
760,		23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to	ath. Do not enter the mode of the consequence of th	olyng, such as cardiac or why AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	respiratory arrest, RETT ANDS		Approximate intervel Between Onset and Deeth 7 M / W 8 M / W 8 M / W
Division of Vital Records, P.O. Box 6876	0 20	that initiated events	d. Due to (or as a consequence of): Contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause					year the cause of death?
	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Mapner of Death 1 Thatural 5 Pendin investig investig and investigations.	28a. Date of Injury (Month, Day Year)	home, farm, street, factory, of	26. Place of Death (Other: 4 Nursing Hom- Injury at 28 Work? 1 Yes 2 No	24a. Wes an aut performed? 1 Yes (Check only one) e 5 Residence id. Describe how inj	avai com of do 22 No 1 [] 6 []Other (Specify) ury occurred	ra eutopsy findings flable prior to spletton of cause eeth? Yes 2 No
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	29a. Certifier 1 Certifying	g Physician: To the best of my kn Examiner: On the basis of examinand mariner stated.	owledge, death occurred at that and/or investigation, in	ne time, date and placa, an my opinion, death occurred cense number	d due to the cause(I at the time, dete ar	s) and manner as sta	the cause(s)
	State Registra	1111 1 0	who completed cause of death (ite	10Gley AL	2/150 AM	UNAPOL	15 Mdz	:1401

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24572

	Certificate of Death	Я	eg. No.					
	Decedent's Name (First, Middle, Last)	2. Dete of Death Month Dey Yeer 3. Time of Deeth						
Physician /Medical	EVA DOVE		7 2000	2003				
> Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Loc		4c. County of D					
	ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS		ANNE AL	RUNDEL				
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Dey	Yeer) 9. f	Birthplece (Stete or Foreign Country)				
Director	219-03-0754 1 M 35 F 92 Yrs. Months Deys Hours Min. (Month, Dey, Yeer) Country) Usuel Residence of Decedent							
/lend	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits				
Man H sh Hod	MARYLAND ANNE ARUNDEL ANNAPOLIS							
vith the Mar or 28a-f s be notified	10e. Streef and Number 10f. Zip Code	1	0g. Citizen of Whaf	Country?				
h wit	36 CORNHILL STREET 21401		IIC 3					
r theme 23s	36 CORNHILL STREET 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Spering Forces) 14. Mexican, Puerto for If Yes, specify Cuban, Mexican, Puerto for If Yes, specify Cuban, Mexican, Puerto for If Yes, Specify Cuban, Mexican, Puerto for If Yes, If Yes, Specify Cuban, Mexican, Puerto for If Yes,	cify Yes or No-	14. Race - A	e - American Indian, ck, White, etc.				
72 hours after natural, or the fical Examinated by Fu	1 Never Merried 2 Merried 1 Yes 2 No			Specify: BLACK				
filed within 72 hours after deeth with the Maryland Hygiene. Hygiene, fratural, or items 23s or 25s-f show ent, the Medical Examiner must be notified at a Completed by Funeral Director.	3 DAWidowed 4 Divorced Year or Detes:							
led within 72 ho yglene. her than "naturi if, the Medical	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the complete of the complete o	na	16b. Kind of Busine	ss/Industry				
d within jiene.	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)							
Hygien Hygien Ather th	7th 0 LAUNDRY DEPT.	US NAVAL ACADEMY						
	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme							
Mer Mer	JOHN W. PARKER SARAH J							
		Route Number, City or Town, Stete, Zip Code)						
s 1 and f Heelth itsm 27 other tr								
permit. Pages 1 ar Department of Hee Important: if itsm 2 eny Injury or other Brica.	20e. Method of Disposition 1⊠Buriel 2 □ Cremation 3 □ Removel from State 4 □ Donetton 5 □ Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) ANNAPOLIS MEM. GARDENS	7/24/	20c. Location - City OO ANNA!					
mit. F partm portar y Inju	21. Signature of Funeral Service Licensee # 00 483 22. Name end Address of Fecility							
Departi Importu eny Inj	WM. REESE & SONS							
		APOLIS	MD, 2	Approximete				
4	23a. Part1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r rospiratory an	031,	Interval Between Onset end Deeth				
Physician / /Medical	Immediate Ceuse (Final			Maria				
Examiner	disease or condition resulting in death) a. CAN 199 FF/2/02	MINS						
	Due to (or es e consequence of):							
ned ned	b. TRRythonia							
al-tra	Sequentially list conditions, if eny, feeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.							
icate be executed physicien and is the burist-transit	cause. Enfer Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or es a consequence of):							
ng phy as the								
law requiras that the daath certificate be executed es been signed by the attanding physicien and 2 should be detached for use as the burial-transit noieted by Physician/Medical Examit	d							
at the daath celd by the attendireleached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death						
v requires that the deben signed by the should be detached ileted by Physic	I DO OF PL	1 Yes 2 No 3 Probably 4						
as tha general period de	Louis G 1 13 reed	~						
he law requiras t hes been signe ige 2 should be o		24a. Was a		b. Were eutopsy findings eveilable prior to				
s bed s sho		pano		completion of cause of death?				
The law requir: sate hes been si page 2 should		1□ Y	es 2000	1 ☐ Yes 2 ☐ NO				
Men: T								
Physicien: The law riths certificate hes by and director, page 2 s	exeminer? Hospitel: Other:		ence 6 Other (S	(pecify)				
Physician: 1 ar this certifical eral director, p	27. Menner of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury et		ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
oding ith: After a fun	1 Anaturel 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28f. Location (Street end Number or Rurel Route Number, City or Town, State)						
or Attending ster death. Director: Aftar i in by the fune	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office							
of in din	27. Menner of Deeth Carried Street							
	29a. Certifier Charles and December 1992 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, e	end due to the d	euse(s) end manne	r es steted.				
he Hospi in 24 hou he Funer pletaly fil	(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred end menner steted.	ed et the time, o	ate end plece, end	oue to the cause(s)				
Withir Comp	29b. Signature and tellvol certifier 29c. License number	11	29d. Date signed (M	onth, Dey, Year)				
	1 10 CW/M DAM 35 49	7/196	000					
600	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)		C 1					
	Stella Voscich House Alvish it	w	erter					
State	31. Date filed (Month, Day, Year) 32. Pegistrer's Signeture							
Registrar	111 2 0 2000 Janes D. spains							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Felicia Helena Dishong July 21 2000 11:00 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8016 Ritchie Highway Pasadena Anne Arundel If Under 1 Year 8. Deta of Birth (Month, Day, Year) Oct. 9, 1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Months Days Hours 213-22-0801 86 Director Montana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show say injury or other traumatic event, the Medical Examiner must be notified at pince. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Elizabeth Road 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Nevar Merried 2 Married 1 ☐ Yas 2 X No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. A Specify: 3KWidowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hospital 12 Nurse 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) 89 2 Julia Gailiunite Joseph Skabisky 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth V. Wagner / daughter 516 Elizabeth Rd. Glen Burnie, MD 21061 20b. Piece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 Cremetion 3 Removel from Steta St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7-24-00 Annapolis, MD. 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funaral Service License 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only ona cause on each lina. Approximete Intervel Between Onset end Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 □ Unknown been signed t should be det Records. þ Be Completed 24a. Wes an eutopsy performed? 24b. Wara autopsy findings aveilable prior to completion of cause of death? page 2 s certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: director, 25. Wes case referred to medical 26. Piece of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 19 Other (Specify) 2010 Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Livino this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Division 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Severna Par 230 enniter

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)
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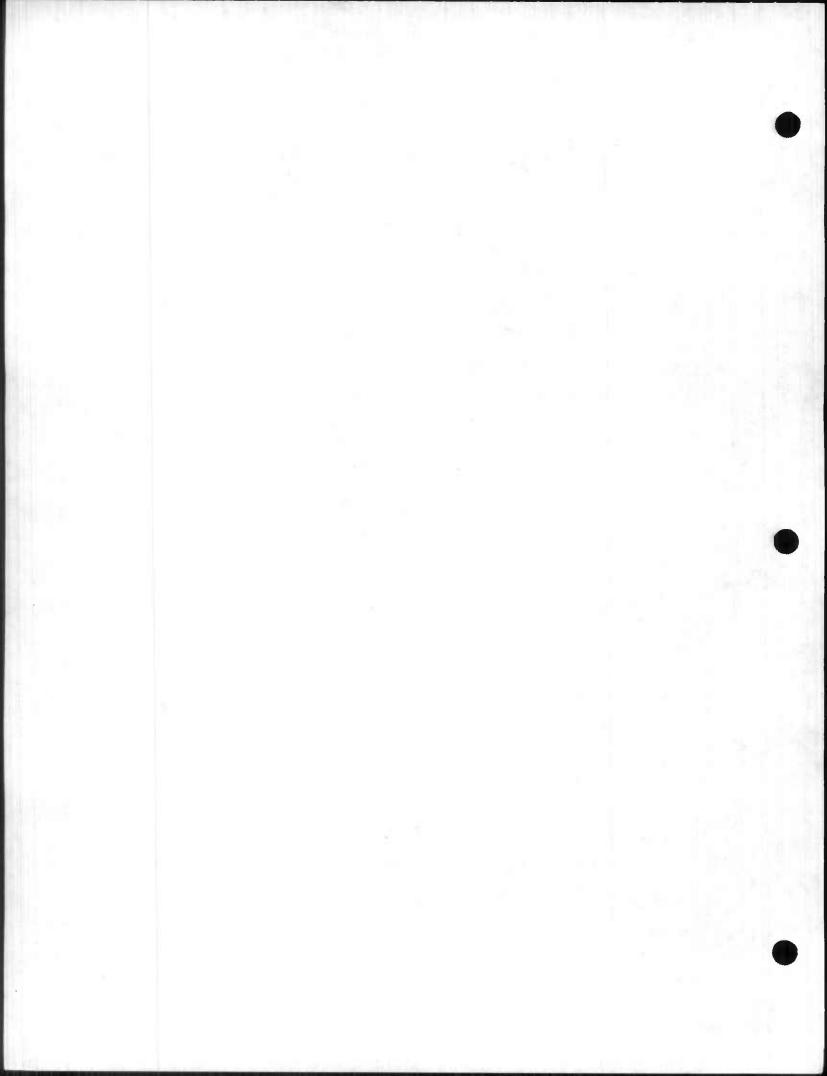
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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filed within 72 hours after death with the Menyland Hygiene. ther than "natural", or flems 23s or 28s-f ehow ent, the Medical Esertime must be notified at	Funeral Director	11. Meritel Status	12. Was Decedent Evar Armed Forcas?	in U,S.	13. Was	s Decedent of Hes, specify Cub	lispanic Origin? (San, Mexican, Pue	Specify Yas or Nato Rican, atc.)	o- 14. Rac Blac	e - Americ k, White,	
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d 2 should th end Mer 7 ie merke traumatic		19a. Informent's Neme/Relationship (T)	rpe, Print)	19b.	Mailing A	Address (Street	and Number or F	lural Route Num	ber, City or Town,	Stata, Zip	Code)20640
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of Heal	1	20a. Method of Disposition 3 ☐F		Ob. Place of cemeter,	Disposition of the control of the co	on (Neme of ory or other pla	ca)	July	20c. Location -	City or To	wn, Stete
Pages nent of h		4 □ Donetion 5 □ Other (Specify)		Mount	Oli	vet C	emetery		OWashin	gtor	D.C.
The Party of		21. Signature of Funaral Sarvice Licens			22. N	eme end Addre	ess of Fecility				
Depa Impo		mon	#	00550	Wil	lliams	Funera	1 Home	,P.A.	5-0	20640
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	:	30. Neme end address of person who c	mplated ceuse of death	(Item 23a) (Type, Pri	nt)					
		B. Larry Jenk	ins, Jr.,	MD,	P.O	. Box	1724, I	La Plat	a, MD	20	646
® State	e	31. Data filed (Month, Dey, Year)	32. Registratr's	Signature	6	1	1				
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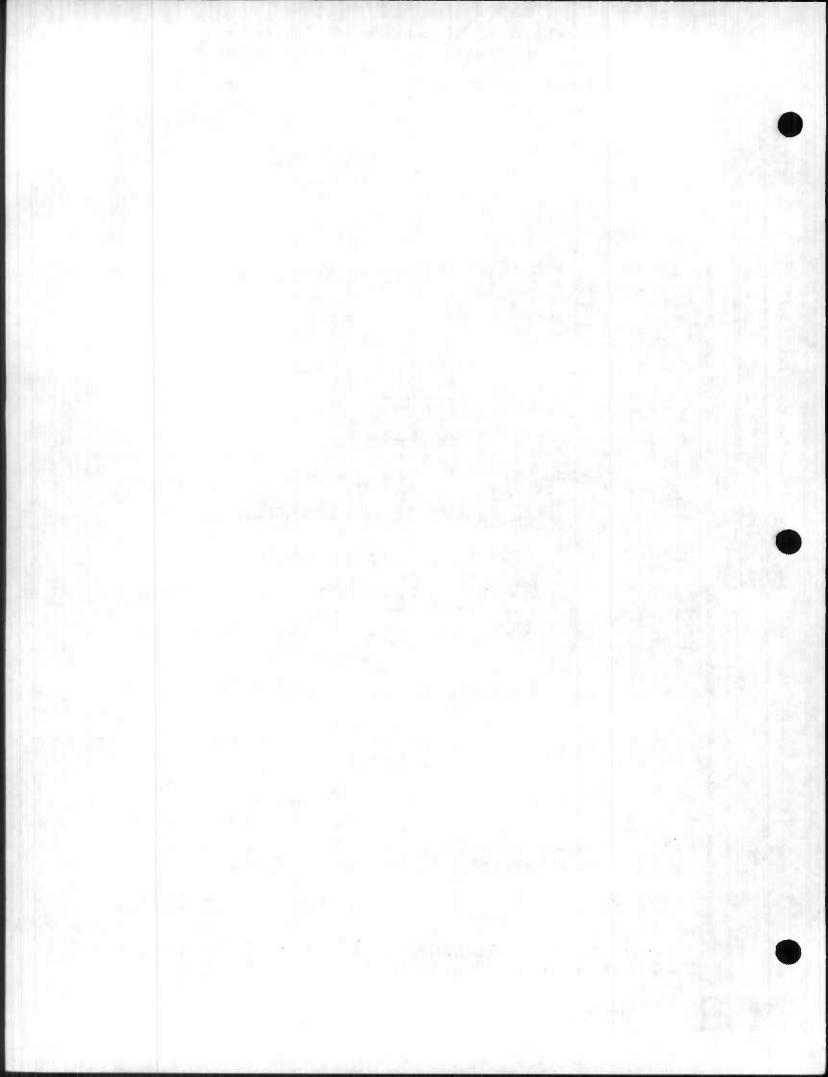


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year ALEJANDRO ELIAS MOISES 07 26-11:05 2000 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death George's Itospital Center Cheverly Prince If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min. 1 M 2 F Hours INFANT YIS NONE July, 23 Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Pres 2 No EITS VILLE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number BLUD. AMI 20705 3906 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. Never Merried 2 Merried Yes 2 No Specify: El Salvado Specify: Itispame 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LNFANT WONE -LINFANI LWIANI 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elias GOUZAICS Alejandro LUZ 19e, Mormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 390.4 (0.04) BIVA, APT. IV 76454: III, MA 20705 ost. CTR Georges RINCE 20e. Method of Disposition 20b. Place of Dispo 1 ☐ Burial 2 ☐ Creg 5 (2969464999) complications that caused the death. Do not exonly one cause on each line. Approximete Intervet Between Onset end Death Intractable y potensions Immediate Cause (Fine diseese or condition resulting in deeth) Intravascular Coagulation Vissenivated Due to (or es e consequence of). Due to (or es e consequence of): rematurite 23b. Did tobacco use contribute to the cause of death? Premothorax (left) 1 Yes 4 No 3 Probably 4 Unknown Distress Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 Yes 2 No 1 Yes

Physician /Medical Examiner

physician and the burial-transit

950

signed by the a

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director,

funeral

After

n 24 hours after deeth.

Property of Funeral Director: After

To the To the To the F

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2

Certification:

Box 68760

P.O.

Records,

Division of Vital

Physician

Funeral

Director

7 is marked other than "natural", or flams 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "I any Injury or other traumatic event, the Mass

Baltimore, Maryland 21215-0020

/Medical

10a. Stete

Directo

Funeral

by

Completed

Be

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Physician/Medicai þ Completed Anennia

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I.

Md 20785

25.	Wes case referre examiner?	
27.	Menger of Death	
	1) Netural	5 Pending

5 Pending investigation 6 ☐ Could not be

28a. Dete of Injury (Month, Dey Year)

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 17 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier

NO

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

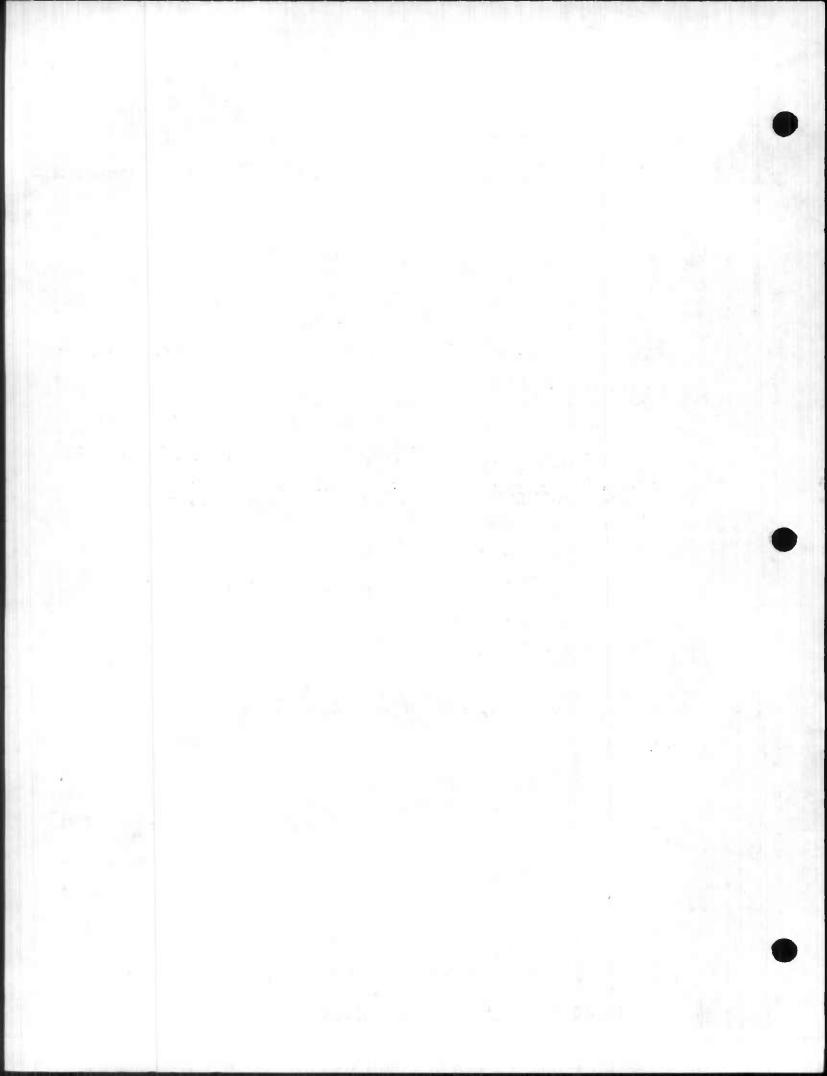
29c. License number 027628 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frattarola, M.D. Isabelita G.

State Registrar 31. Dete filed (Month, Day, Year)
AUG 0 3

32. Registrer's Signature

Prince George's Hospital Center 3001 Hospital Drive, Cheverly, sacks



00-3875-037

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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29d. Date signed (Month, Day, Year)

JULY 14,2000

WILLIAM EASLEY	Certificate of Death Reg. No.											
	1. Decedent's Name (First, Middle, La	nst)	Market Tolland			2. Date of Dea		Van	3. Time of Death			
Physician	William	Darrell	Easley			Month JULY	13,200	Yeer)()	10:30A.M.			
/Medica Examine	de English blance (Manadianain de pai				4b. City, Town, or I		4c. County					
	50678 EASLEY ROAD				DAMERON		ST.MARY'S					
Funeral			e (In yrs. last birthday)	If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Day		place (State or Foreign				
Director	213-46-6207	1 M 2 □ F	55 Yrs.	Months Da	ys Hours Min.	Sept.10	, 1944	Wash:	ington, D.C.			
0	Usual Residence of Decedent											
with the Meryland a or 28a-f show Lbe notting at	Maryland St.	Mary's	10c. City, Town or Lo		Dameron			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10e. Street and Number			10f. Zip Cod	ie	1	log. Citizen of V	What Cour	ntry?			
23a vi	50678 Easley Road	d			20628		United	State	es			
e = 5	11. Meritet Status	12. Was Decedent Armed Forces?	Ever in U,S. 13.	Was Decedent	of Hispenic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-		e - Americ	en Indien,			
Or har affer a		1 Yes 2	No	1 □ Yes 2 翻 I		0 7 110 211 7 0101 7	Specify					
5-0020 72 hours after natural; or the		Year or Dates:		103 2 2	opecny.		эрвспу	Wh:	ite			
Maryland 21215-0020 d2 should be filed within 72 hours at h and Mentel Hyglene. T is marked other than "natural", or traumatic event, the Medical Exem	15. Decedent's E	ducetion ade completed)	16a. Deced	fent's Usuel Oc kind of work do	cupetion one during most of wor tired)	king	16b. Kind of Bu	usiness/In	dustry			
2121 a within piene. r than	Elementary/Secondery (0-12)	College (1-4or	5+) life. I									
d 21		4		Teache				duca	tion			
be filed other ovent, II	17. Father's Neme (First, Middle, Las	1)				ne (First, Middle,		Sumame)				
should be and Mentel of Me	Edward Darrell E	asley			Mary	Lucille	Cullins					
Maryle d 2 should d 2 should the end Merket traumatic traumatic	19a. tnformant's Name/Relationship	(Type, Print)			reet end Number or Ru							
C TO N L	Shirley Karaba /	Cousin			Avenue, W	illoughb	y, Ohio	440	94			
	20a. Method of Disposition	70	20b. Pleca of Dispo cemetery, crer	sition (Name or natory or other	place)	Date	20c. Location -	City or To	own, State			
Y train	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont		Brinsfield	d-Echol	ematory	7-16-00	Charlot	te H	all, MD			
Balting	21. Signature of Funedal Service Liournian 22. Name and Address of Facility Brinsfield Funeral H											
Ball Department of the partment Mary B. Rizzo M01114 22955 Hollywood Road, Leonardtown, MD												
	23a. Part1. Enter the disease or con shock, or heart failure. List only		d the death. Do not ent	er the mode of	dying, such es cardiac	or respiretory en	est,	, FID	Approximate			
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/Medical	Immediete Cause (Final	1	rchosis	,								
Examiner	disease or condition resulting in death)	a						1				
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owecuted an end rial-transit		b	Due to for an a series									
60, be executed ician end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consec	derice or).								
2 P C C C	Cause (Disease or injury that initiated events	c	Due to for so a consul									
ficata ficata	resulting in death) Last		Due to (or as a conseq	uence oi):								
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to tor						ath (Check only or	10)					
- 5 0 D		Hospital: 1 ☐ Inpati		t 3 DOA	Other: 4 Nursing H	lome 5 Resid	ence 6 NOth	er (Speci	WSCENE			
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Vision (Attending P ar death. betor: After I by the funara	2 Accident investigation	tion M 1 Yes 2 No										
ivision rate of the control of the color: of by the	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of in	jury - At home, tarm, str c. (Specify)	eet, factory, off	ice	28f. Location (S City or Tow		ber or Run	al Route Number,			

State Registrar

Medical Ce

29e, Certifier

31. Date filed (Month, Day, Year) JUL 1 8 2000

29b. Signature and title of certifing

30, Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as steted.

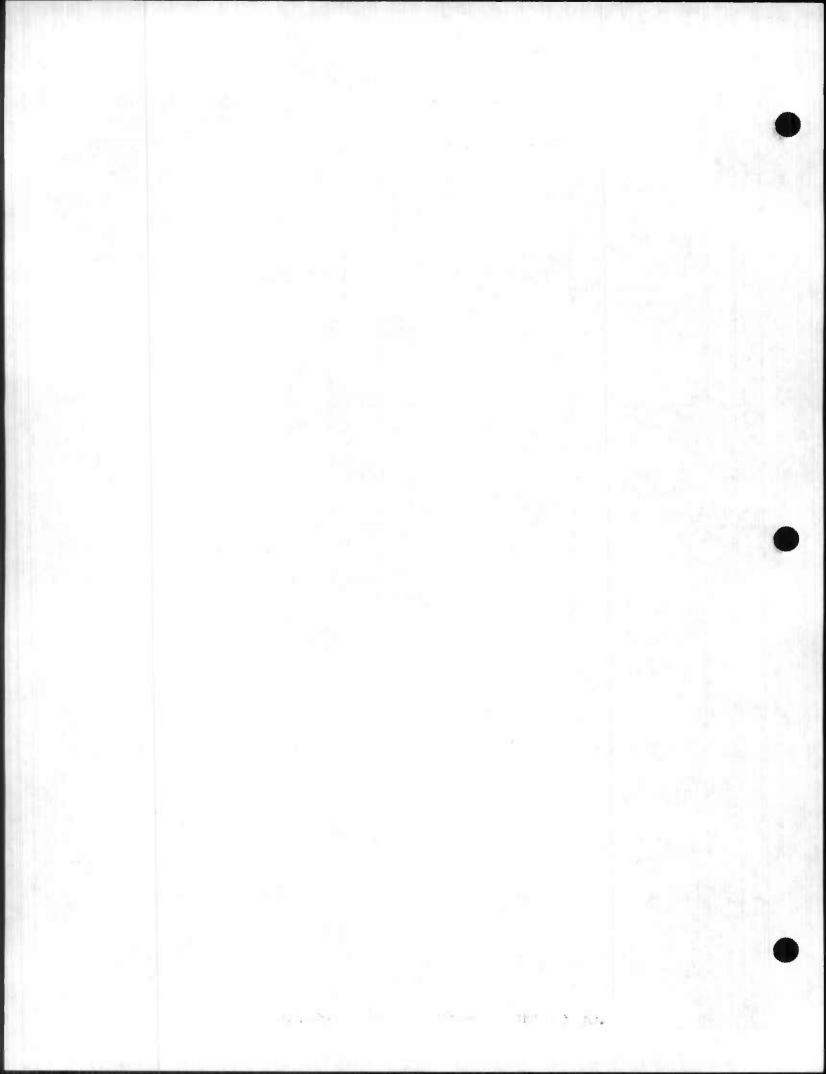
Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and minner steted.

29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene 00 24578

						Certifica	ate of	Death			Reg. No.		
			1. Decedent's Neme (First, Middl							2. Date of De	_	Vana	3. Time of Death
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	/Medic Examin		4a Facility Neme (If not institution	n, give street and number)				4b. City, To	wn, or Lo	cation of Deeth	4c. County	of Deeth	1
	LAditiii	ICI	Frederick M	omorial Hosp	ital			Ewo	dowd	o.le	Ew	040%	f ole
-	F		5. Social Security Number	emorial Hosp	e (In yrs. last birth	dev) If Und	der 1 Year	If Under		8. Date of Birt	h	eder:	
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	Pue Man		10e. Stete 10b. County		10c. City, Town	or Location			-			1	0d. fnside City Limits
	Very	0	Maryland Fred	erick	Fred	erick							X□ Yes 2□ No
	150 I	Directo	10e. Street and Number	elick	Fred		Zip Code				10g. Citizen of W	/het Coun	atn/?
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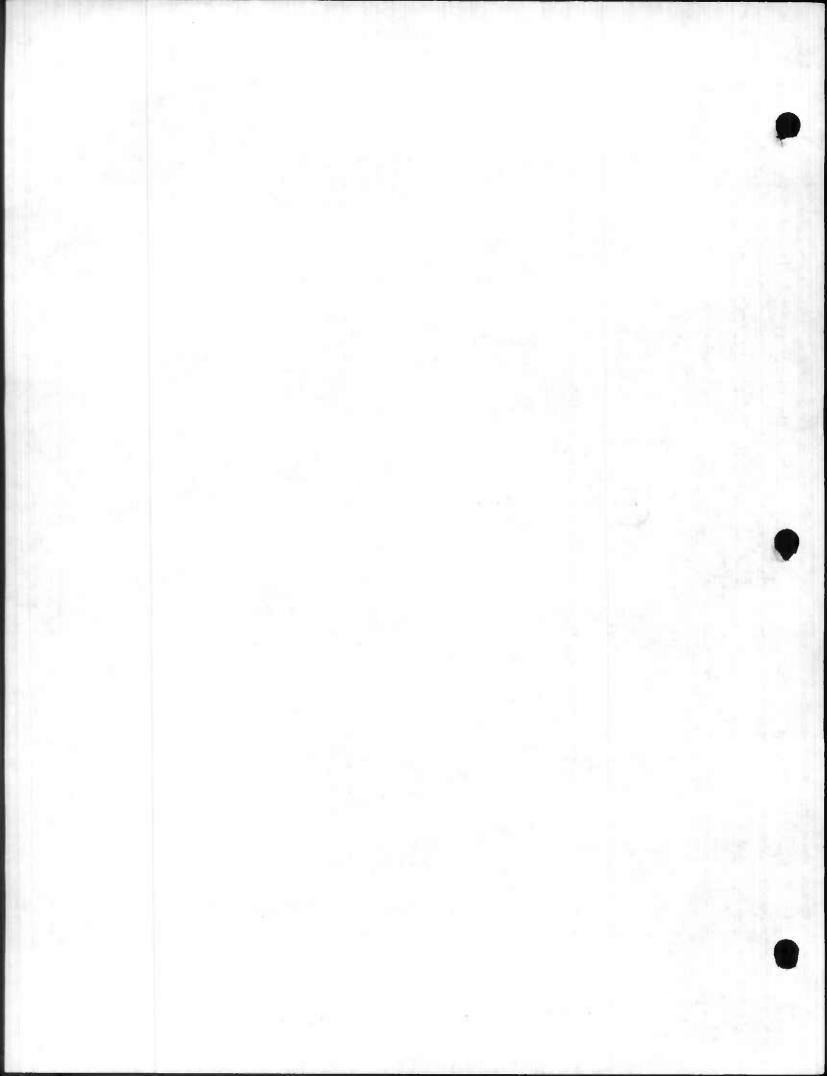
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			30. Name and address of pars	on who com	ALD M	endy	23a) (Ty	S (Cluy	,	0052	128	July	17,20	000
	Sta Registr		John F. Loon 31. Data filed (Month, Day, Ye	R. N.	7. 4To	7 Ju	rime	y He	le Ra	20#30	4 Sev	mu Pu	-KIMD	21146

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State of Maryland / Department of Health and Mental Hygiene 00 21.580

						Certi	ificate	of I	Death			Reg. No	o		C 28	000
	Dt		1. Decedent's Name (First, Middle, Last				X.				2. Date of De Month	ath Da	ıv	Year	3. Tim	e of Death
ς.	Physici /Medic		Joseph Alv:	in Foster								22	2000		11	:30 PM
	Examir		4a Facility Name (If not institution, give	street and number)				4	b. City, To	wn, or L	ocation of Deat	h 4c	. County	of Death		
A)	Funeral Director		SHADY GROVE 5. Social Security Number 6. Se 226-30-7798 10 Usual Residence of Decedent		ST HOS (In yrs. last bit	rthday)	If Under 1	Year Days	If Under Hours		8. Date of Bir (Month, Da Dec. 1	th 1y, Year, 2, 1				te or Foreign
- Paris	ž		10a. State 10b. County		10c. City, Tow	m or Loca	tion							1	Od. insid	e City Limits
And Market Manual	T T	tor	Maryland Montgome:	rv	Gait	hersl	burg								101	es 2 No
4	x 28	Director	10e. Street and Number			10f. Zip Code						10g. Ci	tizen of V	Vhat Coun	itry?	
4	238	ai D	11950 Marmary Ros	ad			20878					U	.S.A	. 1		
d	fre nous area ream war use manyan "naturel", or items 23a or 28a-1 show ad cal Examiner must be nothed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 12 Yes 2 1 N If Yes, Give Year or Dates:			as Deceder res, specify Yes 2		ispanic Or in, Mexical Specify:		ecity Yes or No Rican, etc.))-		Americ k, White,		1,
5	rite call		15. Decedent's Edu			. Deceder	nt's Usual (Occup	ation			16b. F	(ind of Bu	siness/Inc		
2 4	2	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5-	4)	(Give kir	nd of work NOT use	done o	duning mos ()	t of work	ring					
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Maryland Z1Z15-00Z0	and Mental Hygis le merked other reumetic event, to	Be C	17. Father's Name (First, Middle, Last)						18. Moth	er's Nam	e (First, Middle	, Maidei	n Sumam	Θ)		
9	Ind Mental	To	Turner Foster						Min	nnie	Lentz					
	N pur		19a. Informant's Name/Relationship (T)	pe, Print)	198	b. Mailing	Address (Street	and Numb	er or Au	al Route Numb	er, City	or Town,	State, Zip	Code)	P1 111
E .	27 le		Florence G. Foste	r - Wife	1	1950	Marm	ary	Road	1, Ga	aithers	burg	, Ma	ry1a	nd 2	0878
baltimore,	Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, phos.		20e. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	temoval from State	20b. Place of cemeter Parkl.	ry, crema	tory or oth	er plac			Date 7/26/00			City or To		
Ş.			21. Signature of Fundal Service Licens 23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	illiams	the death. Do	264	401 R	Mo idg	leswo	rth	P.A., Damascr or respiratory a	ıs.			Approxi	372-01 male Between nd Death
di i	hysician /Medical xaminer)c	Immediate Cause (Final disease or condition resulting in death)	Metasta	cic non			11	1ung	cano	cer			:	8 m	onths
death certificate be avecuted	attending physician and for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Due to (or as a											
1	d for	icia	Part II. Other significant conditions cor	stributing to death bu	t not resulting l	lo the und	lorbring on	ico chi	on in Part		225 Did	tobacco	0 1100 000	ntelbuta te	the car	se of death
, i	ed by th	by Physician/	Coronary Arter		i not resuming i	in the driv	onying cau	230 giv	OTHER ALL							4 X Unknow
Physician: The law requires	s been s 2 should	Completed b							4		24a. Was	an auto ormed?	opsy	av	ailable pi	osy findings for to of cause
E e	pag	Co									10	Yes 2	No No	1 [∃Yes	2 X No
9	ortific ctor,	Be	25. Was case referred to medical examiner?							e of Dea	th (Check only	one)				
fing Physician	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/O	utpatient Time of Injury	280 M	. Injur	4 114		ome 5 Resi 28d. Describe				'y)	
lor Attending	aftar deat Director: d in by the	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, to . (Specify)	arm, stree					28f. Location (City or To			er or Rura	al Route i	Number,
To the Hospital	n 24 hours Funeral	edicai C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	nician: To the best of nar: On the basis of and manner sta	examination ar	e, death o	occurred al stigation, in	the tim	ne, date ar pinlon, dea	nd place, ath occur	and due to the red at the time,	cause(s	s) and ma nd place,	end due to	tated.	se(s)
To th	To the	Me										29d. D	ate signe	d (Month,	Day, Yes	ar)
	21-0									D 33224 July 23, 2000						
			30. Name and address of person who co R. Trehan, M.D.				rint)			10 1	Marri I					
	Sta	ite	31. Date filed (Month, Day 101)	50 West 1	Signature	LON I	4	лос	KVII	re, l	narylan	a Z	0852			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death July 22, 2000 **Physician** 12:15 AM Lloyd Armistead Gray /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Bayside Care Center Lexington Park St. Mary's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 11, 1924 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1MM 2□ F Yrs 218-14-2033 75 Director Usual Residence of Decedent Menylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow the Madical Examinat must be notified at 1 Yes 2 No Funeral Director Maryland St. Mary's Lexington Park \$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 22153 Knight Court 20653 death Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith end Mental Hygiene. 27 le marked other than °r r traumatic event, tre Elementary/Secondary (0-12) College (1-4or 5+) 8th Machinist Civil Service Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Peges 1 and 2 should be fight of Heelth end Mental I in: If Item 27 is marked of Ethel Cathaline Thompson Issic Daniel Gray 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and Depertment of Heelth Important: If Item 27: any Injury or other transcriptors. 22153 Knight Court, Lexington Park, Maryland 20653 Ruby Gray (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 17/25/2000 Leonardtown, Maryland 21. Sign thre of Funeral Service Licens 22. Name and Address of Fecility.
Mattingley-Gardiner Funeral Home, P.A. Box 270, Leonardtown, Maryland 20650 P.O. 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or a consequence of) Physician/Medical Examiner ner physician end the burief-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760, Due to (or es e consequence of): 980 signed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 30 3 Probably 4 Unknown Division of Vital Records. à 24b. Were autopsy lindings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? Cerrohan 1 Yes 2 No 20 No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Sursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? - Watural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital Continue Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

In the death occurred at the time, date end place, and due to the cause(s) and manner as stated.

In the death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29s. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who co opleted cause of seath (Item 23a) (Type, Print) California, Maryland 20619 James C. Boyd, MD 31. Date filed (Morth, Day, Year) JUL 2 5 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

101 25 Hatt June 10 Harris

State of Maryland / Department of Health and Mental Hygiene

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						Ce	rtificat	te of	Death			Reg. No.			
		1. Decedent's Nama (First, Midd	la, Las	it)	1. 1.11						2. Data of De		Day Year		a of Death
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/Medic Examin	_	4e Facility Neme (If not institutio	n, give				MICCL		4b. City, To	wn, or L	ocation of Deet	h 4c. Count	y of Death		
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Funeral		5. Sociel Security Number	6. Se		7. Age (In)	rs. last birthday		r 1 Yaer	If Under	24 Hrs.	8. Data of Bi (Month, Da				ita or Foraign
Director		414-20-6349	1	□ M 2 🔭 F	78	Yrs.	Months	Days	Hours	Min.		14, 192	Vi	rgin	
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the Maryland 28a-f show notified at	Directo	Maryland St.	Ma	ry's		Great 1	Mills						1 ☐ Yes 2 ☑ N		
E 22	S.	10e. Street end Number					10f. Zip	Code				10g. Citizen of	What Cou	intry?	
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G 80	Funeral	11. Maritel Status		12. Was Dec	edent Evar i	1 U,S. 13.	Was Dece	dent of H	lispanic On	igin? (Sp	ecify Yas or No		ca - Amari	can Indian	٦,
72 hours after death with the Maryla natural, or leans 23e or 28e-f show steal Examiner must be notified at	by	1 Nevar Married 2 Mar 3 ¼ Widowed 4 Divorced		1 Yas If Yas, G Yaar or I	2 ⊠No iva	If Yes, specify Cuban, Maxican, Puarto R 1 ☐ Yas 2 ☒ No Specify:						Speci	4	ite	
E ho	pe	15. Deceder				16a. Dece	dent's Usu	al Occup	ation			16b. Kind of E	Businass/Ir	ndustry	
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o ave	To B	Melvin Cr	ism	an	B ₁₁	rton			Eli	7.3		Stidh	nam		
marks marks	۴	19a. informant's Name/Ralations					ing Address	e (Straat			rel Boute Numb	er, City or Town		in Code)	
0.00		Roberta Evans)							Mills,			20634
Health Im 27 ther t	-	20a. Mathod of Disposition	(Du	agricer		b. Plece of Dispo			15 00	al c,	Date	20c. Location			
0 H 0		1 St Burial 2 □ Cramation	3 🗆	Removel from	State	cematary, cre	matory or o	other plac		!					
and in		4 Donation 5 Other (Specify) Trinity Memorial gardens 7/15/2000 Waldorf, Memorial gardens Of Funarel Sarvice Licensee 21. Signature of Funarel Sarvice Licensee 22. Name and Address of Fecility Mattingley—Gardiner Funeral Home, P													ind
Mport my in		21. Signature of Funarel Sarvice	Licens	see			2. Name at	nd Addre	ss of Fecili	dine	r Fine	cal Home	D	Δ	
88201		The caloned	200	· Vala	din			_	_			n, Mary)
		23a. Part1. Entar tha disaase, or shock, or haart failura. List	comp	lications that	caused the	Do not en	ter tha mod	de of dyir	ng, such es	cardiac	or respiretory a	rrest,	and	Approxi	mata
hysician		shock, or haart tailura. List	only o	na cause on	ech line.									Onset a	Between ind Death
/Medical		Immediate Causa (Final												11.	
xaminer		diseasa or condition rasulting in death) a. ATTHE ON CHRONIU RENAU FAILURE											- 1	4we	٠٠٦
	-					o (or as a conse	quence of)	:					i	200	
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g physician and as the burial-transit	edicai Examiner	Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or injury			Dua to	o (or as a conse	quence of):						i	-	
cian	E E	cause. Enter Underlying Cause (Disaasa or injury		C	HYPERTO	MILH								30+	YRS
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ed of the	Sic	Part ii. Other elgnificant condition	ons co	ntributing to d	eath but not	resulting in the u	indarlying o	causa giv	en in Part	l.	23b. Did tobacco use contribute to the cau				ee of death'
as mat me death of gned by the atten- be detached for u	Physician	Tohma	460	Linn							100	Yee 2□ No	3 Pr	obably	4 🗆 Unknow
requires mar been signed b	by	1 SIMITES	N/BIN	CATTO								•			
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shoul	et		410	נ טאט גי	tream	t					pen	omeur	0	ompletion f death?	
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is certificate ha				1 TOPP	10000							Yes 2 No	1	☐ Yas	ZU NO
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in the second	Certification:	1 ⊠Netural 5 ☐ Pandir		(Mon	of injury th, Day Year	28b. Tima o Injury		28c. Injur Wor		No	ZOU. DASCIDO	how injury occu	ii (ed		
after death. Director: After d in by the fune	cat	2 Accidant investi	М		Yas 2	No									
P Ct	E	2 3 Suicide 6 Could not be datarmined 28a. Place of injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or F City or Town, Stata)									ber or Ru	ral Routa I	Number,		
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within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifier (Check only one)	g Phy Exami	iner: On tha b	best of my lasis of axam ner stated.	cnowledge, deat ination and/or in	h occurred vastigation	at tha tir n, in my o	na, data ar pinion, dea	nd place, oth occur	and dua to the red at the tima,	causa(s) end n data and plece	ennar as , and due	statad. to tha ceu	sa(s)
ompo	× ×	29b. Signatura end titla of certifie	f				29	c. Licens	e number			29d. Data sign	ad (Month	, Day, Yes	er)
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	-		ma		. 12										41.0
		30. Nama and address of person DR . KHA						ITA.	MD. 2	2061	9				
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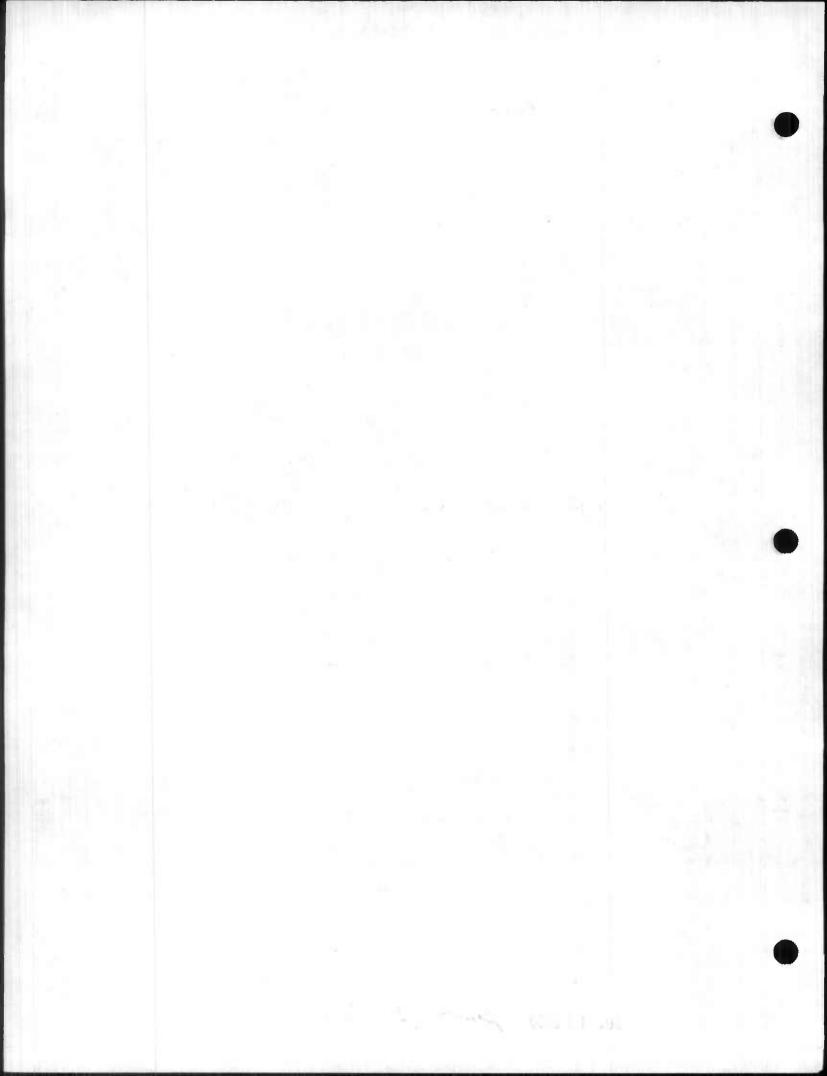
DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

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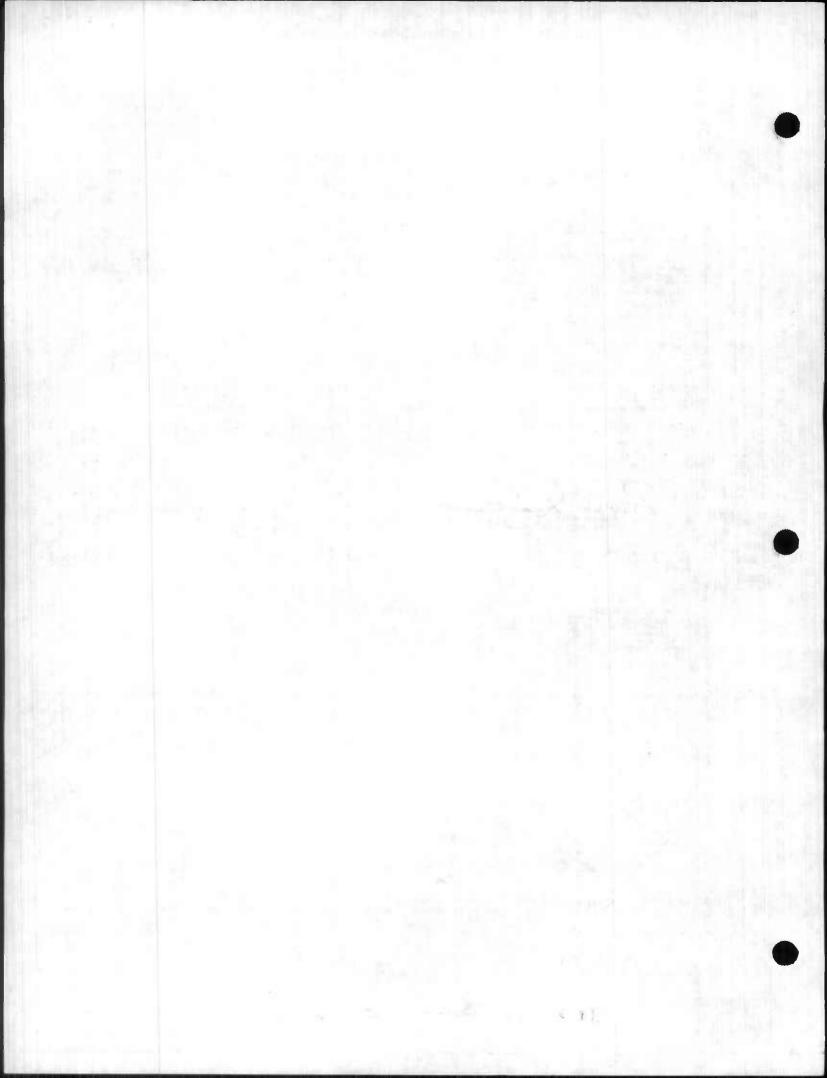
NAME: VIRGINIA GUNTER

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 00 24583

			Ce	rtificate of	Death	Re	g. No.	7 44000							
		Decedent's Neme (First, Middle, Last)				2. Dete of Death		3. Time of Death							
	Physician	CLEVELAND THURMAN GE	ROVE			Month July	19, 200	3:57 PM							
	/Medical Examiner	4e Facility Neme (If not institution, give street and num.	ber)		4b. City, Town, or L		4c. County o								
	Examine	Frederick Memorial Hospit	tal	0111	Frederick	C	Fred	lerick							
	Funeral	5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)			8. Dete of Birth (Month, Day,		Birthplece (State or Foreign Country)							
	Director	216-22-8759 1 ² M 2□F	70 Yrs.	Months Deys	Hours Min.	Dec. 29,	1929	Maryland							
9		Usuel Residence of Decedent				,									
	ylan	10a. Stete 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits							
	Mer To	Maryland Frederick	Frederi	ck				1 ☐ Yes 2 ☐ No							
	vith the Mer or 28a-f all be neathed	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wi	net Country?							
	deeth with the Meryland ms 23a or 28a-f show martite motified at		nit #5102	2170	1		U.	S.A.							
	after death with the Menylar or items 23a or 28a-f ahow nites must be notified at Funeral Director	11. Merital Status 12. Was Deced	ant Evar in U,S. 13.	Wes Decedent of	Hispanic Origin? (Sp ban, Mexican, Puarto	ecify Yes or No-		- American Indian,							
0	or items		No No			Hican, etc.)		, White, etc.							
以 2 2 3	E La		es:	1□ Yes 2 No	Specify:		Specify:	White							
GROVE 1215-0020	ed within 72 hours ygiene. or than "netural", it, the Mexical En-	15. Decedent's Education	16a. Dece	dent's Usuel Occi	pation	ina 1	6b. Kind of Bus	iness/Industry							
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17.	d within giene.	10		aborer			Constr	uction							
P	should be filed and Mental Hygis marked other imatic avant, II	17. Fathar's Nema (First, Middla, Last)			18. Mother's Nam	e (First, Middle, M	aiden Sumame)							
AN	Mental Mental arked o	Edward NMI Grove			Emma	Mae Boon	e	Fig. 1. The second seco							
EVELAND	W = _ =	19a. Informant's Name/Reletionship (Type, Print)	19b. Meili	ing Address (Street	et end Number or Rur	ral Route Number,	City or Town, S	itate, Zip Code)							
	1 and 2 Health e arm 27 ls ther tra	Genevieve M. Grove (Wife)			ater Court	Unit #5	102, Fr	ed., MD 21701							
CI	of He	20e. Method of Disposition	20b. Plece of Disponantery, cre	osition (Name of metory or other pi	ace)	Date 2	0c. Location - C	City or Town, State							
Ĕ	Pages net: If Its iry or o	1 Bunal 2 Cremetion 3 Removel from St 4 Donetion 5 Other (Specify)	Mount 01			7/22/00 F	rederic	k, Maryland							
CL.) Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any Injury or other tu pages.	21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.													
m	P P P P P P P P P P P P P P P P P P P	1 2 15C ()													
		23a Pert I Enter the disease or complications that cal	used the death. Do not en	201 NORT	H MARKET S	or respiretory erre	ERICK,	MD 21701 Approximate							
	Dhusisian	23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory errest, Intervel Beh Onsat and I													
	Physician /Medical	Immediate Cause (Final	tre la	1- b.	DI was			4							
	Examiner	disease or condition resulting in deeth)	n name	1/4/10	var ar		1	many y							
	<u> </u>	() H	Due to (or es e conse	quenca of):	0	0.	Den.	10000							
	executed in end hal-transit	b. 40 k	eroscies	pie i	acano	seuro	15-36	- year							
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89	rificate be ng physicia as the bu	resulting in death) Last	Due to (or es e consec	quenca of):											
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Вох	at the death ce d by the attend etached for us Physician														
o	the de ched	Part II. Other significant conditions contributing to dea	th but not resulting in the u	underlying cause of	jiven in Part I.	/	^	tribute to the cause of death?							
P.0	detay detay	COPU				1,2Ye	s 2□ No	3 Probably 4 Unknown							
Division of Vital Records,	law requiras that the death cert as been signed by the attendim as been signed by the attendim of 2 should be detached for use inpleted by Physician/M	ALL OCAL	1					24b. Were eutopsy findings							
0	The law requir sate has been s page 2 should Completed	Whomisal Worke	· Cherry	m		24a. Wes en		aveilable prior to complation of cause							
ec	law las b s 2 si		9					of deeth?							
Œ	The page					1□ Ye	s 22 No	1 ☐ Yes 2 € No							
ita	ysician: The lav is certificate has director, page 2	25. Was case referred to medical examiner?			26. Plece of Dee	th (Check only one)								
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0	ding Physical After this funeral di	27. Menner of Deeth 28a. Date of (Month,	Injury 28b. Time of Injury	of 28c. Inj	ury at ork?	28d. Describe ho	w Injury occurre	bd							
.0	ath. Per Af	2 Accident investigation			☐ Yes 2 ☐ No										
<u>></u>	or Attandil after death. Director: A d in by the fu	3 Suicide 6 Could not be determined 28e. Place o building	Injury - At home, ferm, st	reet, fectory, offic	8	28f. Location (Str. City or Town,	eet and Numbe State)	er or Aural Aoute Number,							
	lal or Attanding P rs after death. al Director: After t led in by the funer; Certification:														
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	To the trop	29b. Signature end title of certifier		29c. Lice	nsa number	29	d. Date signed	(Month, Day, Year)							
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		30. Nema and addrass of person who completed cause	of deeth (Item 23e) (Type	, Print)											
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	State		gistrers Signatura	4	1		- X -								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Day Physician Mary Virginia Grimes July 19 2000 11:10pm /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Montgomery HCR- Manor Care Nursing Home If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 1□ M 2☑ F Director 219-20-4343 76 Jan. 27, 1924 Maryland Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Maryla 1 ☐ Yes 2 ☑ No Directo Maryland Boyds Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 22510 Slidell Road 20841 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: thems. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American todian 11 Maritat Status Black, Whita, atc. the Medical Examiner pamili. Pages 1 and 2 should be tiled within 72 hours after Department of Matth and Mental Hydjens. Important: If tem 27 is marked other than "natural", or its any hybry or other traumatic event, the Medical Examinate 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) William Franklin Hawse Mary Ellen Keith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) John W. Grimes/ Husband 22510 Slidell Road, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Resthaven Memorial Gardens7/23 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Olin L. Molesworth P. A. Funeral Home 23a. Peril: Enter the disease, or complications, hat caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, 20872 Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final diseasa or condition rasulting in death) Examiner Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last the burial-tran Due to (or as a consequence of): Bud Box 68760. physician Dua to (or as a consequence of): USB &S signed by the atte Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 型 Unknown Completed by cata has been significant page 2 should t 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificata 1 Yas 2 DeNo 1 ☐ Yas 2 No director, 8 25. Was casa refarred to medicat axaminer? 26. Place of Deeth (Check only ona) Other: 45 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 ☐ Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA val or An.

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A in by the funer funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Matural 2 ☐ Accident 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital To the Hospital
within 24 hours a
To the Funeral C
completely filled 18 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end dua to the causa(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29b. Signatura end titte of certifier 29c. License number 29d. Data signed (Month, Day, Year) D37 July 21, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swaroop G. Rao, MD 50 W. Edmonston Drive, #504 Rockville, Maryland

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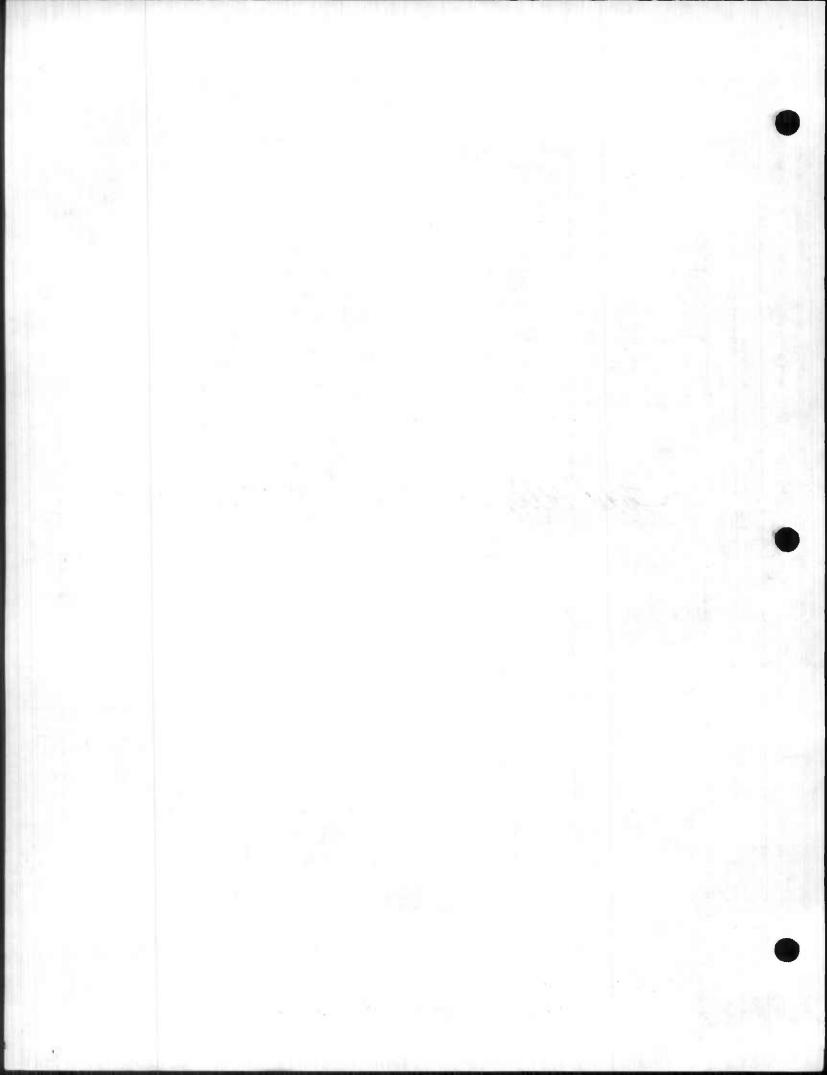
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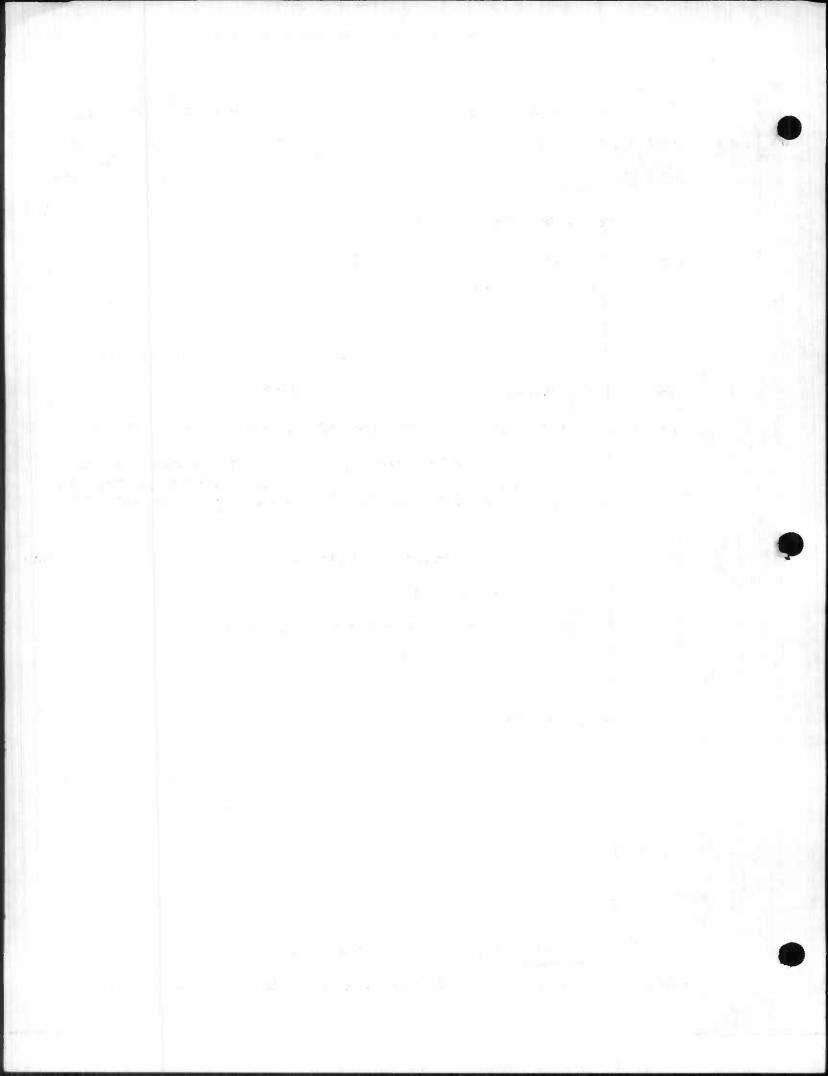
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State of Maryland / Department of Health and Mental Hygiene

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To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by		29a. Cartifiar	1X Cartifying Ph	walcian: To the	place, and due to t	ho causo(s) and i	nannar ac a	stated						
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0 0 N		29b. Signature and		1	_					29d. Data sign		Day, rear)		
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0		30. Nama and addra	ass of person who	completed caus	a of death (Itam	23a) (Type,	Print)				~			
		PADMAJ					•	Road.	Suite 380). Laure	1. MD	20707		
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State of Maryland / Department of Health and Mental Hygiene

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Exam	iner	4a Facility Nama (If not institution, give	street end number)			4b. City, Town, or Le	ocation of Deeth	4c. County	of Death				
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Funera	_	5. Social Security Number 6. Se	X 7. Ag	e (In yrs. last birth	Months Days	Hours Min.	8. Dela of Birth (Month, Day,	Year)	9. Birthpla	ce (Stata or Foreign y)			
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To the Hospital or Attending Physician: The law within 24 hours aftar death. To the Funeral Director: After this certificate has completaly filled in by the funeral director, page 2	Med	29b. Signatore and title of certifier	and mannar st	2100.	29c. Licens	se number	2	9d. Dele signe	d (Month, E	Pey, Year)			
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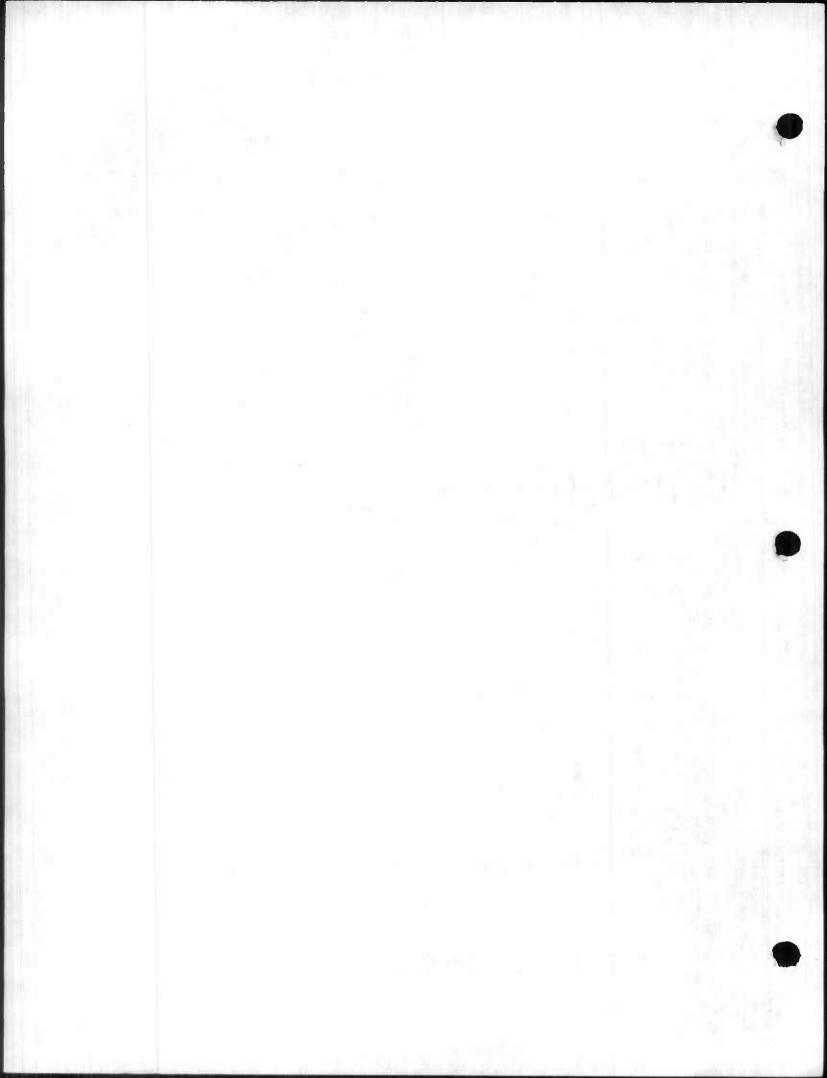
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State of Maryland / Department of Health and Mental Hygiene 0 24587

William Martin Hartsock General Part Control (1997) As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution, pass states and canabasty As Patelly Name of The Institution of The Institution of Name of The Institution of Name						Certif	icate	Of L	Jeath		Re	eg. No.			
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Patricia M. Hartsock/Wife 2242 Bridle Path Drive, Waldorf, Maryland 20601 206. Method of Orloposition 1	To Be	5											(4)		
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D28352 July 24, 2000	0 0	2	J. Tres case referred to intellical	Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing H 28b. Time of Injury (Month, Dey Year) 128b. Time of Injury work?											
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Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646	al director, page 2. To Be Comp	2	examiner? 1 Yes No 7. Manner of Death X Martural 5 Pending investigation 3 Suicide 6 Could not be determined 9a. Certifier Check only 2 Medical Examons) 9b. Signeture end title of cartifier When and address of person who	28e. Dete of Inju (Month, De) 28e. Place of Inju building, etc. 28e. Place of Inju building, etc. 28e. Place of Inju building, etc.	of my knowledge examination atted.	farm, street, ge, death oc nd/or invest	M factory, scurred et igation, is 29c.	1 🗀 ' offica the tim n my op	Yes 2 N	d plece, a h occurred	City or Town	ause(s) and ma ate end place, 9d. Date signe	anner as sto end due to d (Month, L	sted the ceuse(s)	



Registrar DHMH 16 Rev 6/95

AUG 0 4 ...

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) MARY G. RIPPLE, M.D.

29b. Signatura and title of certifiag

31. Dete filed (Month, Day, Year)

32. Registrar's Signatura Gener

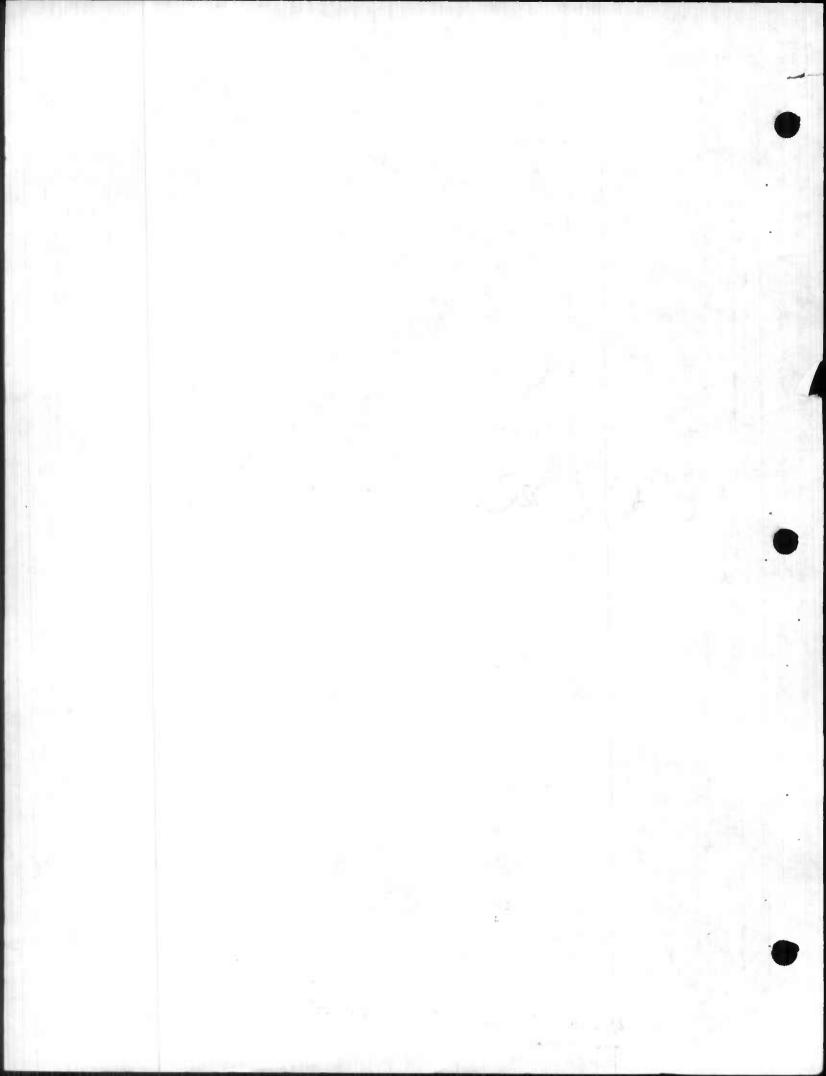
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111 Penn Street, Baltimore, Maryland 21201

29c. Licansa number O.C.M.E.

29d. Data signed (Month, Day, Year)

July 30, 2000

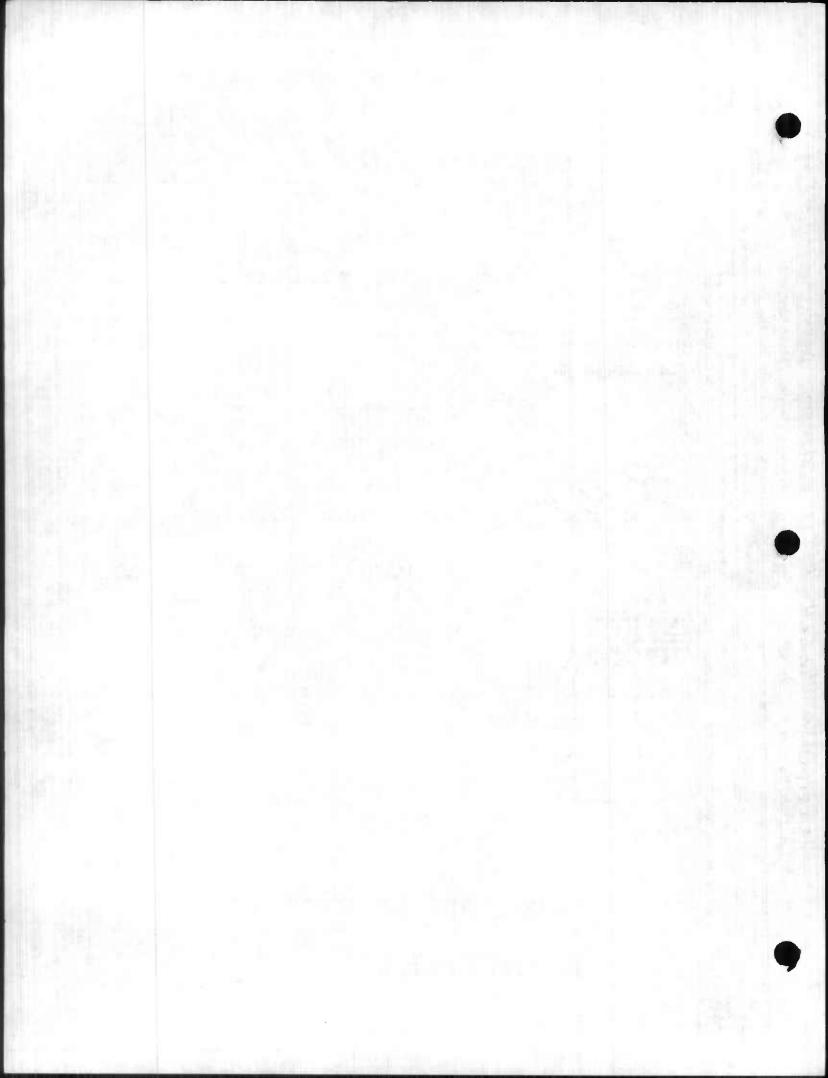


State of Maryland / Department of Health and Mental Hygiene 11 21 599

	Certificate of Death	Reg. I	No.	C 4003
Physician	Decedent's Neme (First, Middle, Last) OLGA SWANN HAMER	2. Date of Death Month	Day Yeer	3. Tima of Death
/Medical Examiner	4a Facility Neme (If not institution, give street end number) Southern Maryland Hospital Center Clinto	ocation of Death	25 2000 4c. County of Death Prince G	
Funeral Director	5. Social Security Number 243-40-1356 6. Sex 1 M 2 M F 84 Yrs. 84 Yrs. 1 Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Yea May 25, 1		plece (Stete or Foreign intry) yland
P 8	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
vith the Maryl or 28s-f sho be notified a	MD Charles Hughesville			1 ☐ Yes 2 No
	10e. Street and Number 15052 Burnt Store Road 20637	Citizen of Whet Cou JSA		
0020 ours after death v reif, or theme 234 Exercises must	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forcesor 1 Never Married 2 Merried 1 Never Married 2 Merried 1 Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto II Yes, Give	pecify Yes or No- p Rican, etc.)	14. Race - Amer Bleck, White Specify: Wh	
1 21215-0020 set within 72 hours at yplene. set than "natural", or it, the Medical Exam Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 16. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Teacher	king 16b.	City E School	lementary
		ne (First, Middle, Meid		
ylar ould b Menta mrked write a		Swann		
Maryland d 2 should be fine th and Mental Hy 7 is merked oth traumatic event	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rus Elizabeth Buckmaster/daughter 13587 Oaks Rd.			
C 22 64 L	20e. Method of Disposition 20b. Place of Disposition (Name of		Location - City or 1	
altimore, mit. Pages 1 a partment of Hes portant: If them y Injury or othe	1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) St. Mary's Newport	7/29/00 0	Charlott	e Hall MD
Balti permit. Departm imports any inju	21. Signature of Funerel Service Licensee MOV0945 22. Name end Address of Fecility AREHART – ECHOLS P.O. BOX 567 I	S FUNERAL	L HOME, P	.A.
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate tntervet Between Onset and Death
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)		2 WEEKS	
	Due to (or es e consequence of):			ZUNDERS
executed in and itel-transit	Sequentially list conditions b. ENTERO CUTAMEDUS FISTULA Due to (or as e consequence of):			Ca Care
ian an urial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underthying Cause (Disease or injury cause)		ZMONTHS	
X 00 00, antificate be executed ding physician and sa as the buniat-transit Medical Examir	that intelled events resulting in deeth) Lest Due to (or as a consequence of):	394		
hat the death cert of by the attendindated for use		nah Didahan		to the sauce of death?
Physic	Pert it. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert it.	1 Yes		to the cause of death? obably 4 Unknown
ires that signed I d be dat	CARCINOMA OF THE PINEAST	24a. Wes an eu		Vere eutopsy findings
al Records, P.O. Box The law requires that the death cert cate has been signed by the attendin page 2 should be datached for usa Completed by Physician/N	CIRRHOSIS	performed	17	wailebte prior to completion of cause of deeth?
f Vital Recystician: The law ysician: The law is cartificate has director, page 2		1 ☐ Yes	20 No 1	☐ Yes 2☐ No
Of VIta Physician: this cartificatal director,	examiner?	th (Check only one)	s Flour (0)	
T whis	1 Yes 2 No rospite: 1 Inpatient 2 ER/Outpetient 3 DOA rospite: 4 Nursing H. 27. Menner of Death 1 Neturet 5 Pending (Month, Dey Year) 28b. Time of Injury Work? 2 Accident investigation	ome 5 ☐ Residence 28d. Describe how in		eny)
Division all or Attending a star death in Director: A od in by that it cat if it cat i	3 Suicide 6 Could not be determined 28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street City or Town, St		rel Route Number,
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and place are considered.			
Within To the comp	29b. Signature and title of certifier 29c. License number		Dete signed (Month	
	39 Name and address of person who completed cause of death (Item 23e) (Type, Print)		1/25/20	D 20755
Ctot	BENJAMIN H. FINDEZ, M.D. 7501 SURRATTS 31. Dete filed (Month, Dev., Year) 32. Registrer's Signeture	RA, CL	MTON, W.	D 20755
State Registrar	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture			

DHMH 16 Rev 6/95

Registrar

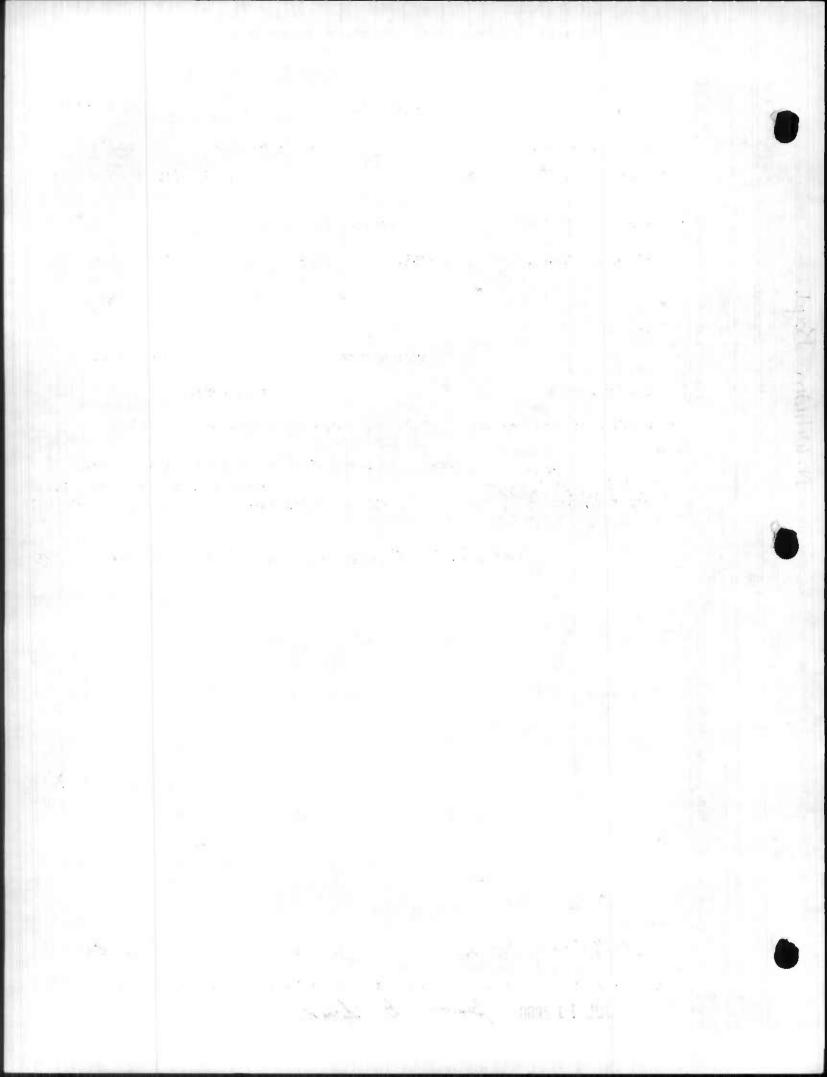


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				4 December No.	- /Final Adidd	f= f ===1	-	-	Cel	lilicate o	Dealli	2. Date of D	Reg. No.		3. Time of Death		
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	Ä	Examir	ner	4a Facility Name (/	f not institutio	n, give street and	number)				4b. City, Town, or	Location of Dea	th 4c. County	of Death			
		Funeral Director		Bayside 5. Social Security N 217-03-	umber	Center 6. Sex 18 M 2 F		ge (In yrs. le	ast birthday) Yrs.	If Under 1 Ye Months Day		8. Date of B		9. Birth	splace (State or Foreign ontry) eW York		
		7		Usual Rasidence of	Dacedent												
		show det		10a. State	10b. County			10c. City,	, Town or Lo	cation					10d. Inside City Limits 1		
		eath with the Mary's in 23s or 28s-f sho must be notified at	Directo	Maryland 10e. Street and Nur		. Mary's	5		Le	onardto 10f. Zip Code			10g. Citizen of	What Cou			
		23s ust b		22680 0	Cedar I	ane Cour	ct, A	Apt. A	#2317		20650		United	Sta	tes		
		ems ems	Funeral	11. Marital Status		12. Was D		Ever in U.S	3. 13.	Was Decedent of f Yes, specify C	f Hispanic Origin? (Suban, Mexicen, Puer	specify Yes or N to Rican, etc.)	o- 14. Rad	ck, White	cen Indian, etc.		
to	020	ours after	by	1 Never Marri 3 Widowed		ried 1 Te	s 221			1□ Yes 2個 N				Wh:			
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3	an	Sed off	o Be	Nathan		211											
5	Y	M M	ř	19a. Informant's Na					19b. Mailir	ng Address (Stre	et end Number or R	sie Ber		State, Zi	ip Code)		
N	ž	saith a m 27 is her tran		Tom Daugh			Rer) .			, Californ						
Dr. William Boy	altimore,	Cot Has If Ham or othe		20a. Mathod of Disp	position	3 Removal fro		20h Pla	ace of Dispo	sition (Neme of netory or other p		Date	20c. Location		own, State		
5	Ë	E and A		4 Donation	5 Othar (S	ipecity)		Imma			of Mary	7-11-0	Lexing	ton	Park, MD		
4	Bal	Depart Depart Import any in		21. Signature of Fall	BUYRY	220		L114	22	955 Ho1	Bı	ad, Leon	nardtown		ome, P.A. 20650-0279		
		Physician /Medical Examiner	er	immediate Cause (diseasa or condition rasulting in death)	'Final	a.Me		TAT	as a consec		Joma	OF I	he C	o)Ca	Interval Between Onset and Death		
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	P.O. Box 687	seth certificate attending phys for use es the	Physician/Medic	resulting in dealin) t	Last	d											
	B	d for	cia	Part II Other elanifi	least conditi	ane contribution to	o doath h	ut not recui	ting in the u	nderiving cause	given in Bart I	23h Di	d tobecco use co	ntribute	to the causs of death?		
							ntributing to death but not resulting in the underlying cause given in Part I.						1 Yes 2 No 3 Probat				
Spould should be							24a. Wa	as an autopsy formed?	a	24b. Ware autopsy findings available prior to completion of cause of death?							
	Re	The law ate hes pege 2	mo									10	Yes 200 No	1	□Yes 20 No		
	ta		Be C	25. Was cese refer	red to medice	t					26. Place of De						
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07/3	0 4	ng Ph (fter th uneral		27. Manner of Death	5 Pendir		ata of Inju fonth, De	y Year)	28b. Tima o Injury	V		28d. Describe	how Injury occur	urred			
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	.∑	or Attendi after death. Director: A d in by the fo	Certification:	4 Homicida	datam	100 ZOU. FI	ace of thi	jury - At hor c. (Specify)	ne, farm, str	eet, factory, offic	08		(Street end Num. own, State)	ber or Hu	ral Route Numbar,		
	Ĭ	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical Ce	29a. Certifier (Check only one)	Cartifyin	Examiner: On the	e basis of	f examination	rledge, death	n occurred at the	time, date and place y opinion, death occ	e, and due to thurred at tha time	a ceusa(s) and m	annar as and dua	stated. to tha causa(s)		
		ithin ithe	Mec	29b. Signature and	title of certifie	and m	anner sta	ateu.		29c. Lice	ense number		29d. Date signe	ed (Month	, Day, Year)		
		F 3 F 8		1	MA	m to	m	20			4285			10-			
				30. Name and addre							out Road.	Leonard					

State Registrar

31. Date filed (Month, Dey, Yaer) 1 2000 32. Registar's Signature

b. space ?



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24591 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 06, **Physician** 2000 7:00PM Emily Elizabeth Roche Hill /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown
If Undar 24 Hrs. | 8 Dafe of I If Undar 1 Year 8. Dafe of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2 F Yes Aug. 30, 1925 Washington, D.C. Director 578-28-7249 74 Usual Residence of Decedent r 28a-f show Inotified at 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 23a 24594 Half Pone Point Road 20636 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within 72 Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Plumbing Secretary 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 ahould be in iment of Health and Menal H tant: If Nem 27 is marked off lury or other traumatic ever Be Lo Cordelia Jones James Garrettson Roche 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24594 Half Pone Point Road, Hollywood, MD 20636 Walter Samuel Hill / Husband 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fune at Service Lights Zion Cemetery 7-10-00 Mechanicsville, MD 22. Name and Addrass of Facility Brinsfield Funeral Home, P.A. My M01114 B. RIZZO 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsef and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thaf initiated events resulting in death) Last pue Due to (or as a consequenca of) Box 68760. Physician/Medical Dua to (or as a consequence of) 80 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 : 1 Yes 2 No certificate 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Dipatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After Division 1 Accident 5 Pending investigation Attending 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 6 within 24 hours a To the Funeral D Hospital The Contifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the fima, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 100 29b. Signature and fitte of certifier 29c. Licansa number 29d. Dafa signed (Month, Day, Year) 9 00

Registrar

State

30. Name and address of person who completed cause DR. JAMES C. BOYD

1 0 2000

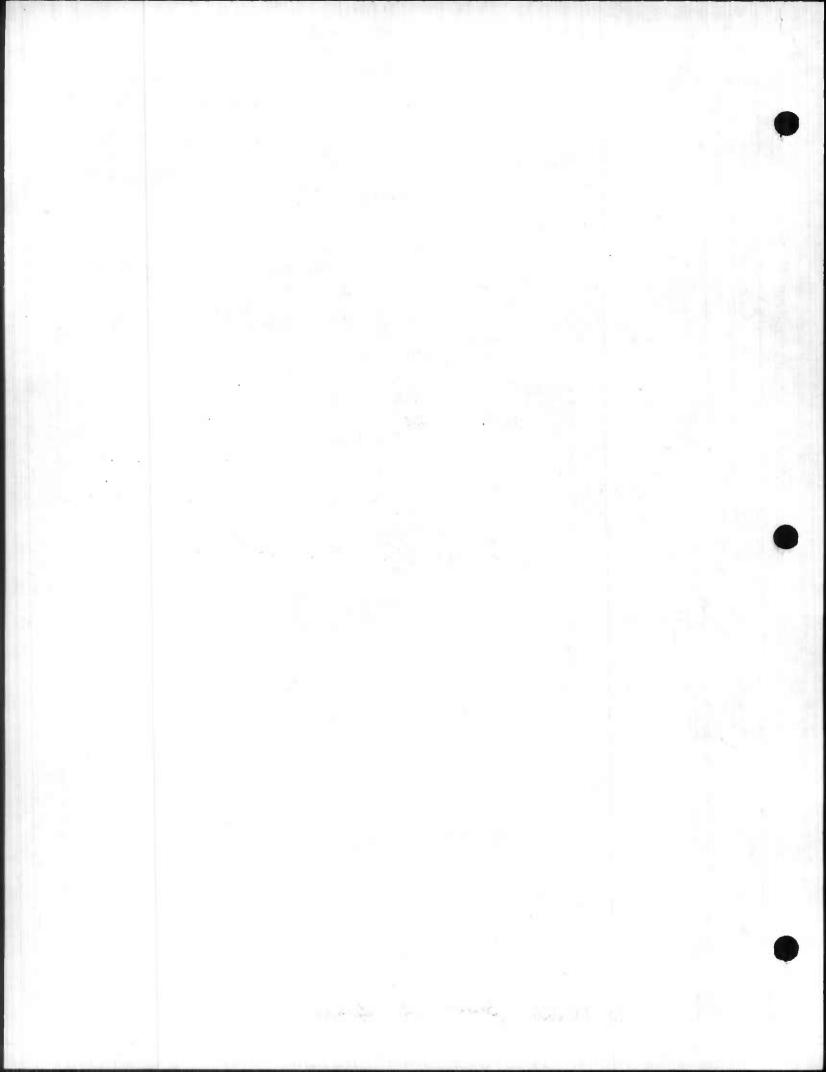
31. Date filed (Month, Day, Year)

20619

oth (Item 23a) (Type, Print)

CALIFORNIA, MD.

Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 Month **Physician** 29, Eleanor Cecelia Hockman June 3:00 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26025 Laurel Grove Road Morganza St. Mary's If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 25 F Director 224-60-6149 May 21, 1908 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Directo 28s-1 Maryland St. Mary's Morganza 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code ð 23a 26025 Laurel Grove Road 20660 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours after Yes 2 No f Yes, Give 1 Never Married 2 Married ð Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: py White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) U.S. Government Executive Secretary years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumetic event Be Johnson Eleanor T. Payne Webster George 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45740 Horsehead Road, Great Mills, Maryland 20634 John E. Allgood (Nephew) 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2000 Oakton, Virginia Flint Hill Cemetery 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21 Signatur e of Funeral Service Lic 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed Iclan and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician the buria Due to (or as a consequenca of) 89 9SD been signed by the ette should be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yea 2 No Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Desplance 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this 28d. Describe how injury occurred funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 Tes 2 No 24 hours after death. Funeral Director: A investigation 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifier (Check only one)

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Ce 29e. Certifier within 2 ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30 00 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) California, Maryland 20619 S. Boyd MD James 31. Dete filed (Month, Day, Year) Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

JUN 3 0 2000

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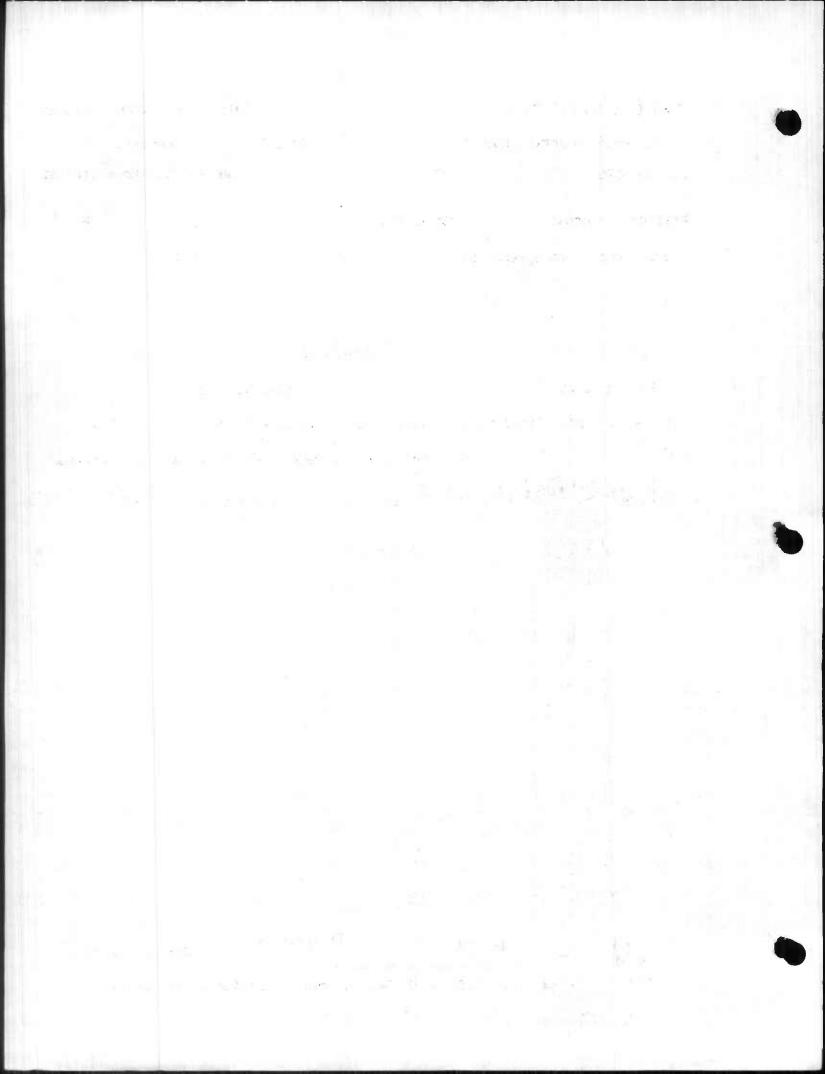
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month 4a. Facility Name (If not institution, give street end number) 16, 9:35 AM July 2000 /Medicai 4b. City, Town, or Location of Deeth 4c. County of Death Examiner McCready Memorial Hospital Crisfield Somerset If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, 9. Birthplace (Stete or Foreign Country) West Virginia **Funeral** (Month, Dey, Yeer) June 16,] 1□M 20 F 86 Yrs. Director 218-20-5625 1914 West Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at 1 Yes 2 □ No Directo Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norms 23a 322 Somers Cove Apartments 21817 by Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. tiled within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 21215-0020 8 1□ Yes 2□tho Specify: White 3 Widowed 4 □ Divorced 'naturaf', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 11 At Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) out be the and Mental by 7 is men Be Pages 1 and 2 should nent of Health and Men Herman Worth 0 traumatic Blanche Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health Important: If Item 27 It any injury or other tra Shirley A. Insley (Daughter) 26417 Burton Avenue - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State St. Peter's Church Cemetery 7/19/00 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, Maryland 21. Signature of Funeral S 22. Nama end Address of Facility y) Black ruitt 306 W. Main St. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Bradshaw & Sons Funeral Home: Crisfield, MD 21817 Approximate Intervel Between Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner NIDDIN The law requires that the death certificate be executed buriel-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physician for use as the bune Physician/Medical Due to (or es e consequence of): signed by the elid be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 21 No 3 Probably 4 Unknown à Completed 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of death? ele 2 X No or Attending Physician: this certifie Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 70 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

D 48098 29d. Date signed (Month, Dey, Year) July 17, 2000 30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Date filed (Month, Dey, Year) 32. Registrar's Signature Registrar JUL 2 0 2000



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State of Maryland / Department of Health and Mental Hygiene

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n Ma		fives	4	0	-	-

	Certificate of	Death	Reg	g. No.	
1.2	1. Decedent's Neme (First, Middle, Last)		2. Dete of Death Month	Day Yeer	3. Time of Death
rsician ledical	JUDITH ALLAN HENDREN			8 2000	14:46
miner	4a Facility Neme (If not Institution, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Deal	th
	SHADY GROVE ADVENTIST HOSPITAL	ROCKVII	LLE	MONTGO	OMERY
1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birth (Month, Dey,)	9. Birt	thplece (State or Foreign
r	414-60-5807 1 M 2 F 62 Yrs. Months Deys Usuel Residence of Decedent	Hours Min.	oct 27	1937	TN
	10a. Stete 10b. County 10c. City, Town or Location				10d. fnside City Limits
tor	MD MONTGOMERY GAITHERSBURG				1 Yes 2 No
Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	ountry?
	15601 ANCIENT OAK DR. 208	78		U.S.A.	
era			pecify Yes or No-	14. Race - Ame	orican Indian,
by Funeral	11. Marital Status 1 Never Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Detes: 13. Was Decedent of I if Yes, specify Cub If Yes, Give Year or Detes:		Aican, etc.)	Black, Whit	e, etc. WHITE
pe	15. Decedent's Education 16e. Decedent's Usual Occup	petion	16	6b. Kind of Business/	ndustry
Completed	(Specify only highest grade completed) (Give kind of work done	during most of world)	king		
mo	Elementary/Secondary (0-12) Collega (1-4or 5+) 4 HOUSEWIFE		Г	OMESTIC	
Bec	17. Fether's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middla, Ma		
To B	JOHN ROBERT KIDD	EDITUD .	TEANINETT	E LOVEL	
-	19e. Informent's Neme/Reletionship (<i>Type, Pnnt</i>) 19b. Mailing Address (<i>Straet</i>)	end Number or Ru	rel Route Number	City or Town. Stata.	Zip Code)
	20e Method of Disposition 20b. Plece of Disposition (Name of	1		C. Location - City or	
	1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete cemetary, cremetory or other ple	'			
	4 Donetion 5 Other (Specify) ENDERS/SHIRLE		7/19	BERRYVII	LLE, VA
	21. Signature of Funeral Service Licent 22. Name end Addre	ess of Fecility FUNERAL	HOME		
	BOX 86.	BARNEST	ITLLE. M	(D 2083)	R
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.	ing, such es cerdiac	or respiratory erres	st,	Approximata Interval Between Onset and Death
1	Immedieta Causa (Finel diseese or condition CEREBROVASCULAR ACCI	DENT			1 day
100	resulting in deeth) a.	DINI			Laay
9	Dua to (or es a consequence of): ATHEROSCLEROSIS				unknown
프	b				dikilowii
Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.				
Sail					
edical	rasulting in death) Last Due to (or es a consequence of):				
3	d		714		
Physician	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause gi	ven in Pert I.	23b. Dld tob	acco use contribute	e to the cause of death?
by Phy			1 🗆 Yes	2 2 No 3 □ P	robably 4 Unknow
Completed b			24a. Was an perform	ed?	Were eutopsy findings available prior to completion of ceuse
dr.				. /	of death?
			1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No
Be	25. Wes cese raferred to medical examiner?		th (Check only one)	
2	1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA			nce 6 Other (Spe	ecify)
	27. Mannar of Death 1 Natural 5 Pending 28a. Dete of Injury 28b. Time Injury 2b. Time	iry at ork?	28d. Describe how	v injury occurred	
atle	2 Accident investigation M 1	Yes 2 No			
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)		28f. Location (Stre City or Town,	eet end Number or R Stete)	ural Route Number,
edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledga, deeth occurred at the time of the control of the basis of examination and/or investigation, in my and manner stated.				
Me	29b. Signature and title of certifier 29c. Licen	se number	29	d. Dete signed (Mon	th, Day, Year)
	De Jol Schoenker MD D26	540			
	Coccio Grand	240		JULY 18	, 2000
	30. Name and address of person who completed ceuse of deeth (flem 23e) (Type, Print)				20877
	Carl I. Schoenberger, MD 16220 Fred	erick Ro	Gait	hersburg	T. MD

DHMH 16 Rev 6/95

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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	-		-	-	40

HARDING

Certificate of Death 1. Decedent's Neme (First, Middle, Last)

2. Date of Death 3. Time of Death Month Day Year

Physician /Medical Examiner

JULIA ELLEN HARDING 4a Facility Name (If not institution, give street and number)

JULY 4b. City, Town, or Location of Deeth 19,2000 8:00P.M. 4c. County of Death

Funeral Director

DORCHESTER GENERAL HOSPITAL 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 1□M 2XF 406-44-3502

CAMBRIDGE If Under 1 Year | If Under 24 Hrs. Months Days Hours

DORCHESTER Birthplaca (State or Foreign Country)

Usuel Residence of Decedent 10a. State

Director

Funeral

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Completed

10b. County

10c. City, Town or Location

Yrs.

8. Dete of Birth (Month, Day, MARCH 7,1936

KENTUCKY

Harna 23a or must be

than "natural", or harr the Medical Examiner

Baltimore, Maryland 21215-0020

filed within

al Hygie other

permit. Pages 1 and 2 should be fit Department of Health and Mertial Hy Important: if then 27 is marriad oth any figury or other traumatic even alby.

Physician

/Medical

Examiner

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signed by the ettending physicien dbe detached for use as the buria

page 2 should Completed

director, Be

this certificate has

After

Director: A

To the Hospital within 24 hours or To the Funeral Complately filled

I or Attending Physician: efter death.

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Certification:

Medical

The law requires that the deeth certificate be executed

Box 68760.

Division of Vital Records. P.O.

MARYLAND DORCHESTER

HURLOCK 10f. Zip Code

1 Yes 2 No 10g. Citizen of What Country?

WHITE

10d. Inside City Limits

10e. Street and Number

321 SOUTH MAIN STREET

64

21643 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

14 Race - American Indian Black, White, etc.

1 Never Married 2 XMarried 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:

1 Yes 2 No Specify: 16a Decedent's Usual Occupation

16b. Kind of Business/Industry

USA

15. Decedent's Education (Specify only highest grade com Elementery/Secondery (0-12)

College (1-4or 5+) YEAR

(Give kind of work done during most of working life. DO NOT use retired) RECEPTIONIST

DENTAL OFFICE

17. Father's Name (First, Middle, Last)

completed)

ANNE MERCER

18. Mother's Name (First, Middle, Maiden Surneme)

ELGAN H. STRADER

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RICHARD P. HARDING/HUSBAND

20b. Pleca of Disposition (Name of cemetery, cremetory or other place)

P. O. BOX 538, HURLOCK, MARYLAND 21643 Date 20c. Location - City or Town, State

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

CAMBRIDGE CREMATORY

7/21/00 CAMBRIDGE, MARYLAND

21. Signature of June al Service Lic

22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 207,

106 MAIN STREET, EAST NEW MARKET, MD ena 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one ceuse on each line.

21631 Approximete tnterval Between Onset and Death

fmmediate Cause (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings aveileble prior to

1 Yes 2 No completion of ceuse of death?

26. Place of Death (Check only one)

INSPECTION

1 ☐ Yes 2 ☐ No

25. Was case referred to medical XYes 2 No

27. Menner of Death 1 Natural 5 Pending investigation 2 Accident

6 Could not be

Hospital: 1 ☐ Inpatient 2 第 ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Dete of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of cartifie

TEODOREM.

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) JULY 20,2000

Mochen 30. Neme and address of person who completed cause death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year) 2 4 2000

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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00) 2	4	C	9	C

			C	ertificate of	Death		Reg. No.		
	1. Decedent's Name (First, Middla, La	ist)				2. Data of D Month	eath Day	Year	3. Time of Death
Physician (Martinal	Harold Lee H	lun t				July		2000	5:40 PM
/Medical Examiner	4a Facility Nama (If not institution, gi	va street and number)			4b. City, Town, o	or Location of Dea	th 4c. County	of Death	
S Examiner	181 Defense High	way			Annapol	lis	Anne	e Aru	ndel
Formula			e (In yrs. last birthde	(y) If Undar 1 Yaar	If Under 24 H			9. Birthpi	iaca (Stata or Foraign
Funeral Director		1⊠M 2□F	95 Yrs.	Months Days	Hours Mi	in. (Month, D	rth ay, Year) 2,1905	Coun	vland
Director	Usual Rasidenca of Decedant					1249	_,	1142	y zuitu
land Man	10a. State 10b. County		10c. City, Town or	Location	1100		12 T N	10	Od. Insida City Limits
Aerylar F show	MD Anne Aru	ın de1	Annapol	ie					1 ☐ Yes 2 ☐ No
the Meryla 28a-f sho notified at	10e. Street and Number	211 402	mapo	10f. Zlp Coda			10g. Citizan of V	What Coun	tn/?
di ya	Toe. Street and Number						rog. Okizari or v	That Ocul	
Interdeeth with the Menyland ritems 23s or 28s-f show their mat be notified at Funeral Director	181 Defense High			214			US		
	11. Maritaf Status	12. Was Decedent 8 Armed Forcas?	Ever in U,S.	3. Was Decedent of If Yes, specify Cub	Hispanic Orlgin? ban, Maxican, Pu	(Specify Yes or Nerto Rican, atc.)	O- 14. Hac	a - America ck, Whita, a	
S at a F		1 Yas 2 X		1□Yes 2√2No			Specify	<i>(: :</i>	
ours ours	3 Widowad 4 □ Divorced	Yaar or Datas:		-X			opus,	Whi	te
1 21215-UU2U ed within 72 hours efter bygiene. The fredice Expens t, the fredice Expense. Completed by Fu	15. Decedent's E (Specify only highest gr		16a. De	cedant's Usual Occu va kind of work done	pation during most of w	vorkina	16b. Kind of Bu	usinass/Ind	dustry
	Etementary/Secondary (0-12)	College (1-4or 5	+) life	. DO NOT usa retire	9d)				
d with		3	Er	gineer			Md. Sta	ate R	oads Comm.
Maryiand 212 d 2 should be filed withi th and Mental Hygiene. 77 is marked other than traumatic event, the M)			18. Mother's N	lama (First, Middle	a, Maiden Sumem	ia)	
Vial Menta M	Robert Murray Hun	t			Carolin	ne Duncar	n Lee		
Maryland 2 d 2 should be filed th and Mental Hygi 7 is marked other traumatic event.	19a. Informant's Name/Ralationship		19b. Me	eiling Addrass (Straa	t and Number or	Rurel Route Num	ber, City or Town,	Stata, Zip	Coda)
M dd 2 dd 2 dd 2 dd 2 dd 2 dd 2 dd 2 dd	Ruth Ann Hunt / o	daughter	181	Defense F	lighway	Annapa	olis, MD	. 214	01
of Health Health Tree trees	20a. Mathod of Disposition	laughter		sposition (Nama of ramatory or other pla		Data	20c. Location -		
2 2 2 2 2	14 Burial 2 Cramation 3					7 1/ 00			100
FIRM Peg Iment Lant: It	4 Donation 5 Other (Speci	fy)	St. Mai	y's Cemet		7-14-00	Annapo.		
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n 29 F 2 2	- Bun	truel		47 Duke o					
	23a. Part1. Enter the disaase, or com	plications that caused	the death. Do not						Approximata
Physician	shock, or haart failura. List only	ona causa on aach lir	18.						Interval Batween Onset and Death
/Medical	Immediate Causa (Final	1	1. 1					i	10.12
Examiner	disaasa or condition resulting in deeth)	a	Typerte	ension					10 years
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hat the deeth certified by the attending place by the attending place and detached for use as the Physician/Mec	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	undarlying causa g	ivan in Part I.	23b. Dfc	l tobacco use co	ntributs to	the cause of death?
" " S & E						10	Yes 2XNo	3 ☐ Prol	bably 4 Unknown
S, F es that es that be determined by P									
HECORGS, P he law requires that s has been signed to ge 2 should be deten						24a. Wa	s en autopsy	24b. W	ere eutopsy findings
oper red			- 07 W			per	formed?	CO	ailable prior to mpletion of causa
						19	-1	of	deeth?
						10	Yes 2 No	10	∃Yas 2□No
Of Vital Me Physician: The L this certificate he ral director, page	25. Was casa refarred to medicet axaminar?				26. Placa of D	Death (Check only	one)		
Physic this ce al dire	1 Yes 2 No	Hospitat:	nt 2 ER/Outpat	ient 3 DOA	ther: 4 Nursing	Homa 5 Ra	sidance 6 Oth	nar (Specif	(y)
a Property of Prop		28a Deta of triju (Month, Da)	Year) 28b. Time		ury at	28d. Dascribe	how injury occur	red	
ath. The fur set fur s	1 Naturat 5 Panding invastigation		routy Injur		Yas 2□No				
OIVISION or Attending after death. Director: After d in by the fune	3 Suicide 6 Could not be determined	286. Piece of Inju	ry - At homa, farm,	street, fectory, office		28f. Location	(Street and Numt	per or Rure	Al Route Number,
DIVISION C ball or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicida	building, ato	c. (Specify)			City or 1	own, Stata)		
ours fille		hysician: To the best of	of my knowledge da	ath occurred at the t	time dete end nie	ace and due to the	a causa(s) and ma	annar as s	tated
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examone)	miner: On the basis of and mannar sta	axamination and/or	invastigation, In my	opinion, deeth oc	courred at the time	, data and place,	and dua to	tha cause(s)
thin the mple	The state of the s	ano marmar sta	ilao.	20c Licer	nsa number		29d. Data signe	d (Month	Day Vagr)
F 1 5 8	29b. Signature and till of condiar	n					07/	-1-	
	Olle	8		D.	29193		04/1.	4/41	000
	30. Nama and addrass of person who	completed cause of de	aath (Itam 23a) (Typ	e, Print)					
	Stephen Killian,	M.D.	180 Admir	al Cochra	ne Dr.	Annano	lis, MD	2140	01
State	31. Date filed (Month, Dey, Year)		ar's Signature	/	4		, , , , , , , , , , , , , , , , , , , ,		
Registrar	NN 1 4 20	no Street	se B.	Anneh	2/				

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Anna **Physician** 4b. City, Town, or Location of Death 20. 2000 11:45 AM /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** 1602 McGuckian St. 7. Aga (In yrs. last birthday) If Undar 1 Year | If Undar 24 Hrs. | 8. (Anne Arundel 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplaca (Stete or Foraign Country) **Funeral** Days Hours Min. 1 M 200 Yrs. 215-18-8466 Director Dec. 25, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 Yes & No Director Maryland Anne Arundel Annapolis 10g. Citizan of What Country? 10f, Zip Code 10e. Street and Number 1602 McGuckian St. 21401 U.S.A. Funeral ntal Hygiene.
ad other than "natural", or liams
c event, the Medical Examiner my 14. Raca - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: à 3 ◯ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cottege (1-4or 5+) Elementary/Secondary (0-12) Civil Service U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits.
Department of Health and Menus hy important: if them 27 is marked oth any fejury or other trearmetic eventables. 17. Father's Name (First, Middla, Last) Be Samuel Hendricks Nettie Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Nancy Cox/daughter MD 1 King Ct. Annapolis, 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Gardens 7/24/00 Annapolis, 21. Signature of Furniral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Annapolis MD
Approximate
Interval Between
Onset and Death 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each tine. Immediate Cause (Final disease or condition resulting in death) 14 months Due to (or as a consequence of): Due to (or as a consequenca of):

Physician /Medical **Examiner**

98

page 2 should

After this

within 24 hours after death To the Funeral Director: / completely filled in by the

þ

Completed

Be

edicai Certification: To

mag 25a or 3

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records.

of Vital

Division

The law requires that the

Hospital or Attanding Physician:

To the

death.

Physician/Medical Examine Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. embolism

23b. Did tobacco use contribute to the cause of death? 1 Xas 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 212010 1 ☐ Yes 2 ☐ No 1 ☐ Yes

25. Was case referred to medicaf 1□ Yes 2€ No 27. Manner of Death
1 Natural
2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 5 Pending investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. tnjury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Read #300 Annaps II, MD

29b. Signature end title of certifiar Canne wer

052830

29c. License number

29d. Date signed (Month, Dey, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Seance Wenner, 900 Gest care Re 31. Data filed (Month, Dey, Year)

JUL 2 4 2000

6 Could not be determined

32. Registrar's Signature

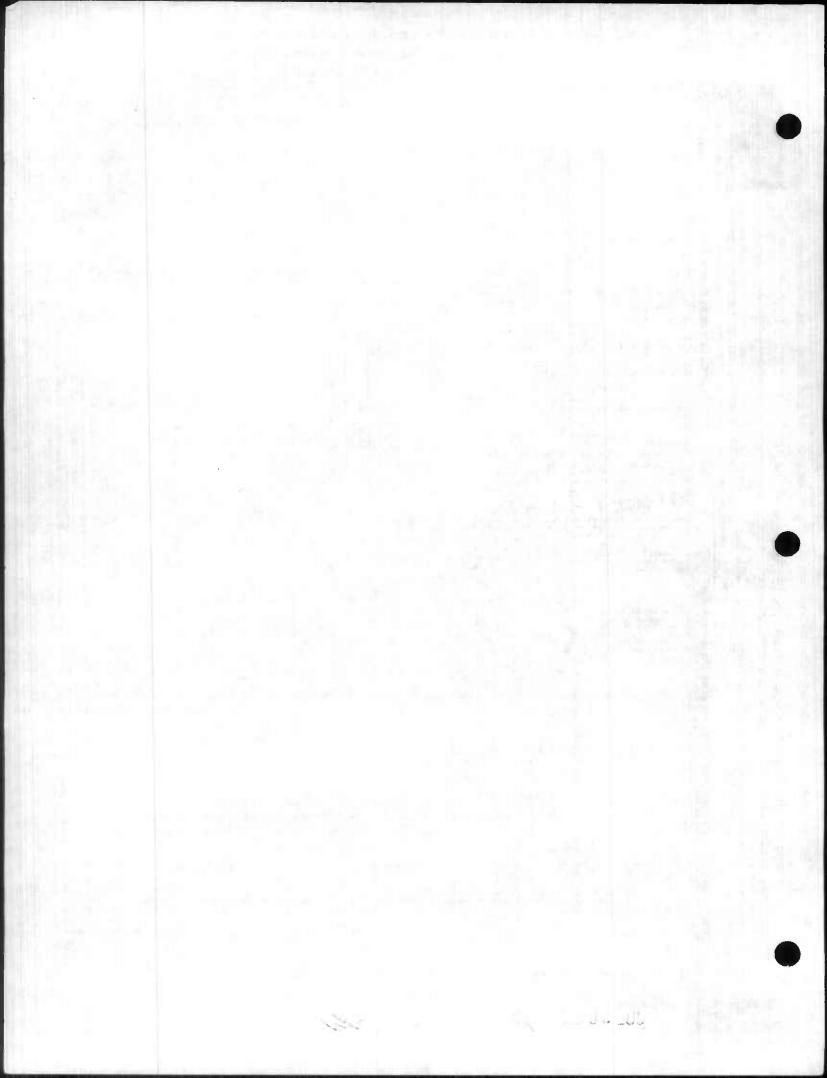
State Registrar

Alexander .

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

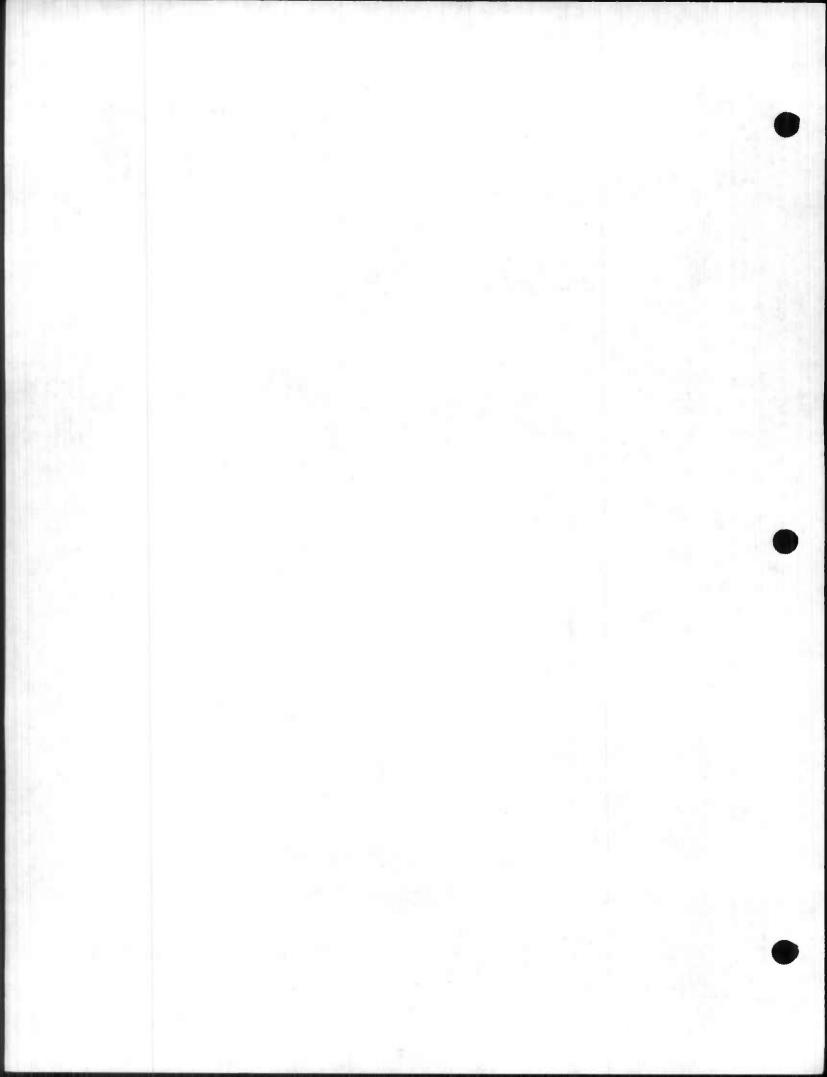
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	/Medical Examiner	4e Facility Neme (If not institution, give			4	b. City, Town, or	Location of Deat	4c. County	of Deeth		
		Good Samaritan	Hospital		516	Balti	more		V/A		
2.0	uneral irector	5. Social Security Number 6. Sec. 1215-14-0315		last birthday) If Un Yrs. Month	der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da March	th y, Year)	9. Birthplece (5 Country)	State or Foreign and	
yland	M M	Usuet Residence of Decedent 10a. Stete 10b. County	10c. Cit	y, Town or Location						ide City Limits	
3	notified in irector	Maryland N/A		Balt	imore					Yes 2□No	
6	or 28e-1 se notifies Directo	10e. Street and Number		10f.	Zip Code			10g. Citizen of V			
6	rai in	3204 Kenyon Avenue				213		u. s			
020 um ahar da	Examiner of by Fune	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		cedent of Hipecify Cube	ispenic Origin? (S en, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	Specify	e - American Ind ik, White, etc. "White	en,	
12 ho	"natural Idical	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decedent's U (Give kind of life. DO NO	suel Occup work done	etion during most of wo	rking	16b. Kind of Bu	siness/Industry		
Maryland 21215-0020 d 2 should be filed within 72 hours et in and Mental Hydiene.	A. the Ma	1st Grade	College (1-4or 5+)	Port					inting		
and the state of t	ic eveni o Be	17. Father's Neme (First, Middle, Last) William Hammel					ne (First, Middle) Donohue	, Maiden Suman	(e)		
T day	T To	19a. Informant's Neme/Relationship (Ty	pe. Print)	19b. Mailing Addr	ess (Street	-		er, City or Town,	State, Zip Code		
Ma Ma	27 is	William J. Hammel		3204 Ken							
ore,	othe	20e. Method of Disposition	20b. F	Plece of Disposition (incometery, cremetory)			Dete	A	City or Town, St		
Page	T OF	1. Buriel 2 □ Cremetion 3 □ R 4 □ Donetion 5 □ Other (Specify)	emovel from State	reland Mem			7/24/00	Baltimo	re. Mari	ll.and	
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- 40		made 1	~	3331	Brehm	s Lane,	Baltimor	ie, Mary			
0		23e. Pert1. Enter the disease, or shock, or heart failure. List	cetions thet caused the deat ne ceuse on each line.	h. Do not enter the n	node of dyir	ig, such es cardie	c or respiretory e	rrest,	Inten	oximate rel Between t end Death	
/M	sician edical miner	Immediate Cause (Finel disease or condition resulting in death)	Sepsi	3	Er.				1		
70/	i i	Tooling in dollary	Due to (c	or es e consequence	of):				21	93/hours	
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. 0	od for	Pert It. Other significant conditions cor	tributing to death but not res	ulting in the underlyin	a ceuse aiv	ren in Pert t.	23b. Dld	tobacco use co	ntributs to the c	ause of death?	
T #	ed by the attending detached for use a Physician/M	2, 3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,					10	Yss 2 No	3 Probably	4 Unknown	
(A) 00	should be del should be del							en eutopsy	24b. Were au eveiteble	topsy findings	
of Vital Record	20 0			*			pen	Jillied !	complete of death	on of cause	
T P	page page						10	Yes 2 No	1 ☐ Yes	200 No	
Vita	s certificate director, pag To Be Co	25. Wes cese referred to medicel examiner?				26. Place of De	ath (Check only	one)			
Physic	500	1 ☐ Yes 2 X No			DOA Oth	4 U Nursing	_	dence 6 Oth			
On C	After funera	27. Manner of Death 1 XINatural 5 □ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur	yat k? Yes 2 □ No	28d. Describe	how injury occur	red		
Division at or Attending	in in	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, ferm, street, fec		166 2 110	28f. Location (City or To	Street end Numb wn, Stete)	per or Rural Roul	e Number,	
Ne Hospital	pletely filled edical Ce	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one)	ilcian: To the best of my knoner: On the besis of examine end menner steted.	wledge, death occurr tion end/or investiget	ed at the tir	ne, date and ptace pinion, deeth occi	e, end due to the urred et the time,	cause(s) and me date end place,	enner as stated. and due to the c	ause(s)	
To the within	To the comple	29b. Signeture end title of certifier	- Triple	dein	29c. Licens	30661		29d. Date signe	d (Month, Dey, 1	(ear) 2000	
	7	30. Neme end address of person who co	mpleted cause of deeth (Iten	n 23a) (Type, Print)	SIRE	ESH T	RIPUR	ANEX			
	5	5601 Loch Rau	en Bluel	Balli	nor		1-21-	239	,		
	State	31. Dete filed (Month, Dey, Year)	2. Registrer's Signe	4							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 11 21.600

1. Decoder's Ferma (First, Modific, Last) 2. Data of Death 2. Da
Examiner Funeral Funeral Teneral Status Teneral Tenera
Funeral Director Funeral Director Social Security Number S. Sax T. Age (in yrs. last birthday) Hunder 1 Year Hunder 24 Hs. B. Date of Birth (Aborth Day Vest Operation) Social Security Number S. Sax Morths Day Hunder 1 Year Hunder 24 Hs. B. Date of Birth (Aborth Day Vest Operation) Social Security Number S. Sax Morths Day Hunder 1 Year Hunder 24 Hs. B. Date of Birth (Aborth Day Vest Operation) Social Security Number So
Security Security
10e. Slate 10e. County 10e. City, Town or Location 10d. Inside City 10e. City 1
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Physician Medical Examiner Physician Immediata Causa (Final disease or condition resulting in daeth) Physician Immediate Causa (Final disease or condition resulting in daeth) Due to (or as a consequence of):
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Per II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco day contribute to the cause of the cau
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of a see a RENAL FAILURE
THROMBOCYTOPENIA 24a. Was an eutopsy performed? THROMBOCYTOPENIA 24b. Were autopsy available prior completion of completion of deeth?
of deeth?
1 Yas 20 No 1 Yes 20 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N
1 Natural 5 Pending (Month, Dey Year) Injury Work? 1 Yes 2 No Year Yes 2 No Year Yes 2 No Yes 3 Yes 4
building, atc. (Specify)
29a. Certifliar (Check only one) 29a. Certifliar (Check only one) 29b. Signature and titla of certifliar 29c. License number 29c. License number 29d. Date sgned (Month, Day, Year)
D 24034
Compacy of one little is the state of the little in the li
30. Name and address of person who complated causa of death (Item 23a) (Type, Print) TIMOTHY LOW, M. D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 21.501.

					ficate of			4.44	g. No.		
	1. Decedent's Name (First, Middle, L	ast)) I = [Data of Deati Month		Year	3. Time of Death
ysician Jedical	CIERRA			HA	RTI	NET	_	Z Uly			10:00 f
aminer	4a Facility Name (If not institution, g	ive street end number)				4b. City, Tov	wn, or Location	on of Death	4c. County		
eral ctor	N/A	Sex 7. Ag 1 □ M 2 □ F	e (In yrs. last t	birthday) If	f Undar 1 Yaar flonths Days	r If Under 2	24 Hrs. 8. 8	Dete of Birth (Month, Dey, Wy 9,		9. Birthpla Country Mary	ce (State or Foreign) Land
	Usuel Residence of Decedent 10a, State 10b, County		10a City To	own or Locati	ion					100	d Inoldo City Limito
*		ima tra	Toc. City, 10							100	d. Inside City Limita 1 ☐ Yes 2 ☑ No
Directo	Maryland Balt 10e. Street and Number	imore			Baltimo	re				10 -10 - 1	
rai Dir	507 Patuxent Av	enue			10f. Zip Code	21237			og. Citizen of V	S.A.	y :
by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Armed Forces? 1 Yes 2 1 If Yes, Give Yaar or Detas:			s Decedent of es, specify Cul		gin? (Specify , Puerto Rica	Yes or No- in, etc.)		ce - Amarican ck, White, at White	C.
Completed	15. Decedent's (Specify only highest g	Education irade completed) College (1-4or 5		(Give kin)	t's Usuei Occu d of work done NOT use retin	during most	of working		16b. Kind of Bu		stry
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To Be	Curtis Jerome								Hartne		
ř	19a. Informant's Name/Relationship		19	9h Mailing A	Address (Stree				City or Town,		Code)
	Philip C. Rahne	held grands	athon							2123	
	20a. Method of Disposition	greater	20b. Pleca	of Disposition	on (Neme of				20c. Location -		
	1 Buriel 2 Cremation 3				ony or other place. Cemeter		7/2	21/00	Raltimo	are M	aryland
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	Buyers (à level	len	Sch 970	imunek 15 Bela	Funer	al Hon	ne, In	C. MD 2	21236	
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Registrar



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State of Maryland / Department of Health and Mental Hygiene

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	4a Facility Name (If not institution,		1 0-	1/	A	or Location of Deeth	/	
		TENN	HUD	NUE		POLIS		NE THUN
_	5. Social Security Number 219-74-2651	6. Sex 7. Age 7. Age	85	birthday) If Und Months	or 1 Year If Under 24 Days Hours N	Hrs. 8. Date of Bird	y, Yel 915	9. Birthplace (Stete or I Maryland
	Usual Residence of Decedent 10a, State 10b, County		100 Ciby To	own or Location				10d. Inside City
-		do 1	Too. Ony, To		napolis			1 € Yes 2
Director	Maryland Anne Ar	dider			-		40 - Olices of W	
ō	10e. Street and Number 15 Eastern Ave.				21403		U.S.A	
by Funeral	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Dates:			edent of Hispanic Origin ecify Cuben, Mexican, P 2 No Specify:	? (Specify Yes or No ruerto Rican, etc.)		e - American Indian, ck, White, etc. White
Be Completed	15. Decedent's (Specify only highest)	Education	16	6a. Decedent's Us	ual Occupation	working	16b. Kind of Bu	usiness/Industry
ple	Elementary/Sepondery (0-12)	College (1-4or 5	+)		ork done during most of use retired)	WOTKING	0 1	
O	12			Homemak			Own l	
Be Con	17. Father's Name (First, Middle, La	ast)			18. Mother's	Name (First, Middle,	Meiden Sumam	10)
	Charles Ridout				Nina I	Pettebone		
To	19a. Informant's Name/Relationship	ip (Type, Print)	1	9b. Mailing Addre	ss (Street and Number o	or Rural Route Numb	er, City or Town,	State, Zip Code)
	Rebecca Huber/da	aughter	2	26450 Mod	re Farm Lar	ne Onanc	ock, VA	23417
5	20a. Method of Disposition		20b. Piaca	of Disposition (Natery, crematory of	ame of other plece)	Date	20c. Location -	City or Town, Stete
	Burial 2 Cremation 3 4 Donation 5 Other (Spe				Cemetery	7/26/00	Annapo:	lis MD
once.	21. Signature of Funeral Service Lie		00. 1	22. Name	and Address of Fecility			,
ouc	1/1/56				M. Taylor H			
		\vee	the death D	147 I	uke of Glou	icester St	. Anna	polis, MD Approximate
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0	25. Was case referred to medical				26. Plece of	Death (Check only	one)	
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o Be	27. Menner of Death	28e. Date of Inju	ry 28	b. Time of	28c. Injury et Work?	-	how injury occur	
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7,005 & 3 JUL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Month July 20, 2000 William 5:45 PM Jenkins /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 27, 1917 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foraign Country) **Funeral** Days Months Hours 1 M 2 □ F 83 Yrs. 215-12-0589 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hame 23e or 28e-f ahow the Medical Examiner must be notified at 1 Yes 2 No Maryland Director St. Mary's California 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 22374 Three Notch Road 20619 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. within 72 hours after 1 X Yes 2 No If Yas, Give Yeer or Dates: 1 ☐ Never Merried 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: py 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 8th College (1-4or 5+) permit. Pages 1 and 2 should be filed with Depertment of Health end Mental Hygien Important: If them 27 is marked other the any Injury or other traumatic avent Truck Driver Concrete Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Ann Rebecca Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Jenkins (Spouse) P.O. Box 234, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Heart of Mary Cemetery 7/27/2000 Lexington Park, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part / Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line. Approximata interval Batween Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner certificate be executed s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as Box 68760 Due to (or as a consequence of) attending for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the been signed by t should be detact 1 Yes 2 No 3 Probably 4 Unknown Records, by

Completed To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 10 Medical Certification:

certificate has

Division of Vital

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? NU

1 ☐ Yas 2 No

2 No 1 Yes

	23. Was case referred to medical			26. Place of Death (Check only ona)						
examiner?		lo	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□	DOA Other:	4 Nursing	Home 5 ☐ Residenca 6 ☐ Other (Specity)		
	Mannar of Death Natural Colored	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28a. Place of Injury	At home, farm, street	et, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29a. Certifie 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.

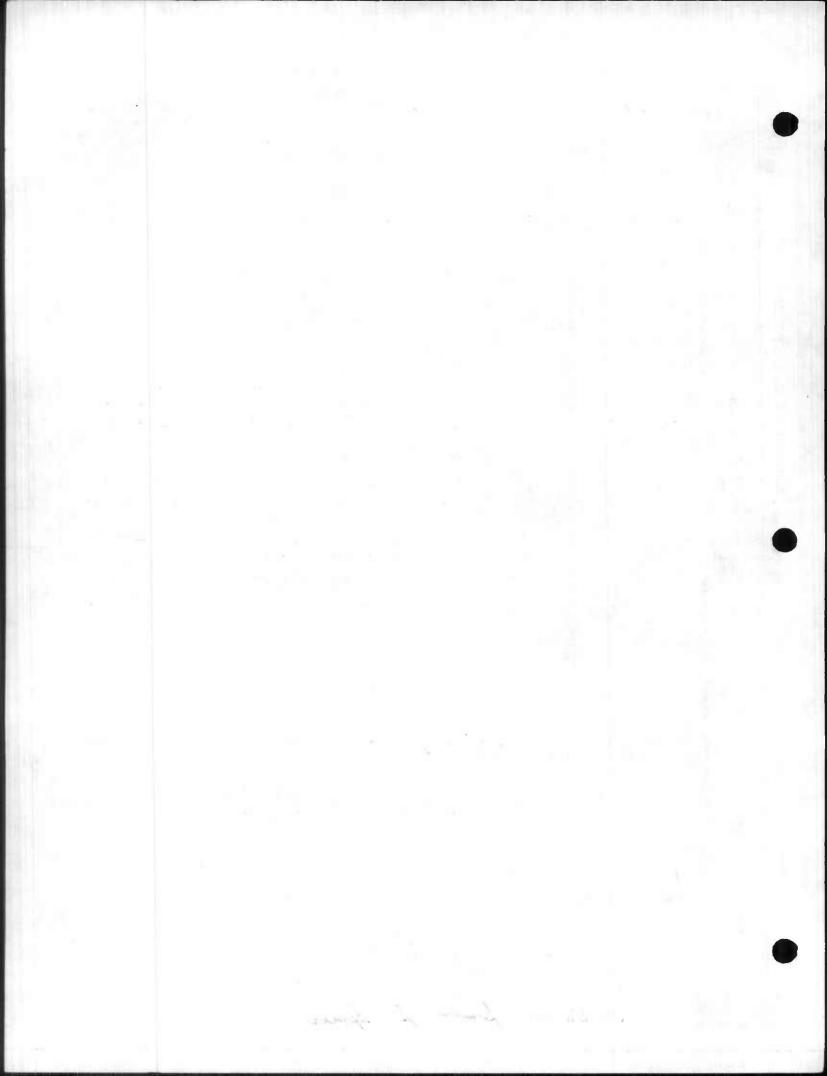
29c. License number

29b. Signature and title of cartifie 29d. Date signed (Month, Dey, Year)

se of death (Item 23a) (Type, Pript) 30. Name and address of person who completed Jarboe, Leonardtown, Maryland 20650 James MD

State Registrar 31. Date filed (Month, Dey, Year) 2. Registrer's Signature JUL 2 5 2000

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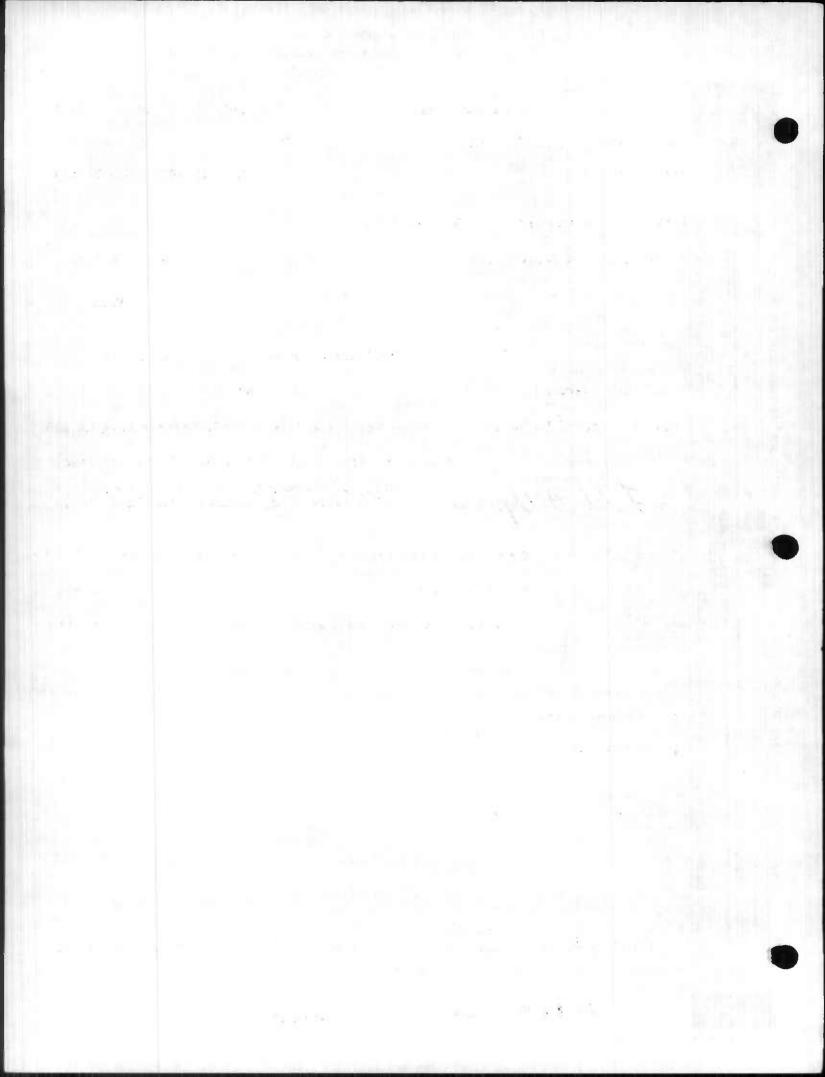
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificat	e of	Death		P	leg. No.		-4004
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/Medi		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo						July ocation of Deeth	4c. County				
Examir	ner	Montgomery Gene											
				7. Age (In yrs. I	la në hirëhala s	If Under	r 1 Year	If Under	lney	9 Date of Birth	Montgomery		
Funeral			1□M 2⊠F						8. Date of Birth (Month, Day,	Year)	9. Birthplece (State of Country)		
Director		155-20-8071		72	110.					June 22	,1928	New	Jersey
show		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	ocation							10d. Inside City Limits
	Funeral Director												1 ☐ Yes 2 No
W T		Maryland Montgomery Gaithersburg									103 249110		
and 21215-0020 be filed within 72 hours efter death with the Manyland tall Hyglene. d other than "natural", or items 23s or 28s4 show event, the Medical Evaluation must be notified at		10e. Street and Number 10f. Zlp Code								10g. Citizen of What Country?			
		25004 Woodfield School Road 20882 Unit								ed St	ates		
	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?			S. 13.	Was Dece	dent of h	lispanic Or	igin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.	
	To Be Completed by Fu	1 Never Married 2 Married	1 ☐ Yes	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:			riidan, ott.)				
		3 ☐ Widowed 4 ☐ Divorced									Specif	Specify: White	
2 ho		15. Decedent's	Education		16a. Decedent's Usual Occupation						16b. Kind of Business/Industry		
215 in 7. in 2. in		(Specify only highest (College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Registered Nurse			ing					
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		William VanderE						17	- 11-	. 1			
aryla should to nd Meni					10h Mail	no Addron	o (Chroni	Emma		nknown	e City or Town	ity or Town, State, Zip Code)	
20000		19a. Informent's Name/Relationship											
CINE		George Kennedy/	Husband	- D	25004	Wood	lfie.	ld Sci	hoo1	Road, (Saither	sburg	Md 20882
S To E		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Demoval from S	^4	lace of Dispo emetery, cre	matory or	me or other pla	ce)	i	Date	20c. Location	- City or 1	own, Stete
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Baltimo		21. Signature of Funeral Service Lic	ensee					ess of Facili					
Depariment important		Olin L. Molesworth P. A. Funeral Home											
-		26401 Ridge Road, Damascus, Maryland 20872 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.											
No. of Lot													
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Division of Vital Re within 24 hours effer deeth. To the Hospital or Attending Physician: The Is within 24 hours effer deeth. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Sati	2 Accident investigat		M 1 7			Yes 2 No						
	Ħ H	3 ☐ Sulcide 6 ☐ Could not determine	d 256. Piece	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	Ce		City of County										
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	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										to the ceuse(s)	
of the office of	Me	29b. Signature and title of cartifier ATTEMP (Month, Day, Year)										, Day, Year)	
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		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)											
		Robert Fields				lip D	rive	, 01n	ey,	Marland	20832		
Sta	_	31. Date filed (Month, Day, Year)	4 2000 b	gistra/s Slgņa	Comment of the commen	16		1					
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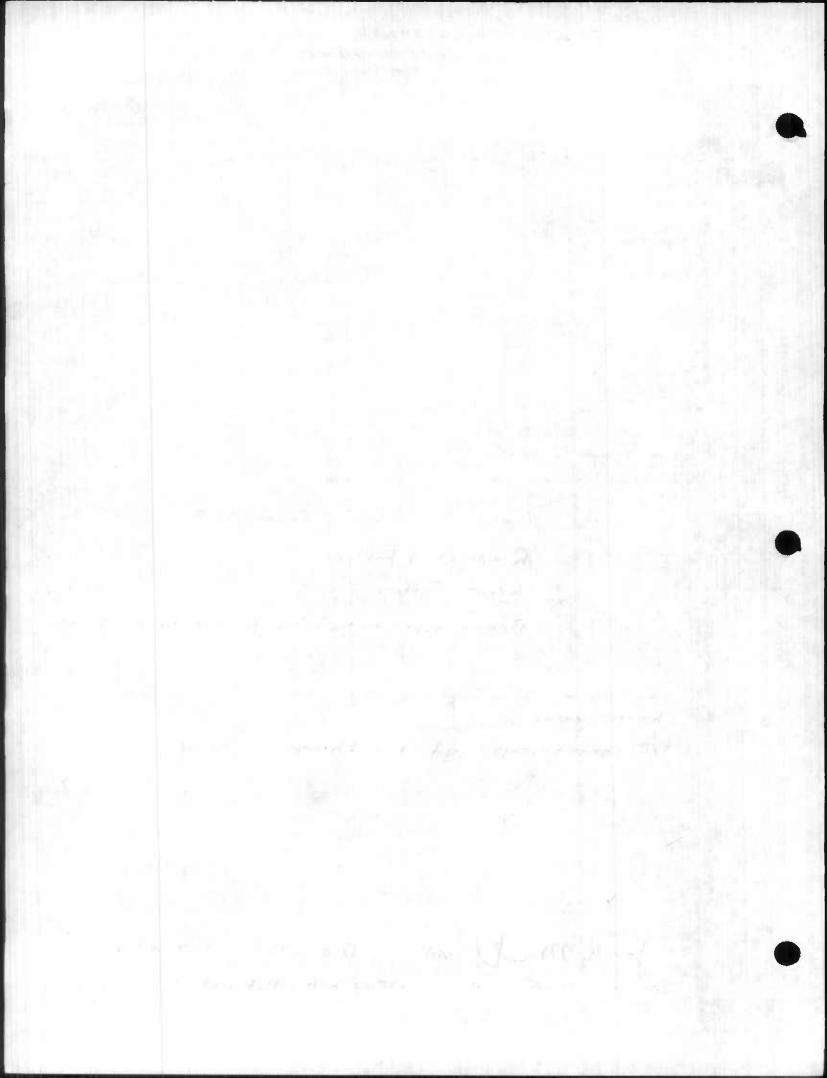
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Tina S. 24 2000 7:30 am Koh Ju1y /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 52 Director unknown Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Columbia . Howard 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number or Nerns 23s 5021 Southern Star Terrace 21044 United States Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Merilel Status filed within 72 hours aftar 1 Never Married 2 Married 1 Yes Mo Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Asian þ 3 Widowed 4 Divorced Year or Detes: "natural". Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiena. Elamentary/Secondary (0-12) College (1-4or 5+) unknown Homemaker Own Home permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic evant 2008. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unknown unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Sam Koh / husband 5021 Southern Star Terrace Columbia, MD. 21044 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition July 27 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Ramoval from State Columbia Memorial Columbia, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 10 4112 Old Columbia Pike Ellicott City, MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrast, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Rispiratory Failure /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner as the bunel-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Diseasa or injury thal infliated events resulting in death) Last Brown + concer my too to tic to liver + box P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown antmia, Division of Vital Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Aftar this cartificate has been si funeral director, page 2 should it chimotheripy, indiatin thimpy. 24a. Wes en autopsy performed? Be Completed 20No 1 Yes 2 No 1 TYAS or Attending Physician; after death. 25. Wes cese referred to medical axaminer? 26. Place of Deeth (Chack only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes XNo 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Injury at Work? Natural 2 Accident Injury 5 Pending To the Hospital or Attendir within 24 hours after daath.
To the Funeral Director: Af complataly filled in by the fu 1 Yes 2 No investigation 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and magner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier D 30573 MU 30. Name and address of person who completed ceuse of deeth (Itam 23a) (Type, Print) 11065 xittle Porturent Porkumy C. Lubi Markey 210 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

2000



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State of Maryland / Department of Health and Mental Hygiene 00 24606

			Certificat	e of Death		Reg. No.	27000				
Physiciar /Medica	111011401 0000		, Jr.		2. Data of De Month July	Day Year	3. Time of Death 10:09 am				
Examine	4a Facility Nama (If not institution, giv	4a Facility Nama (If not institution, give street and number) Anne Arundel Medical Center Annag					th 4c. County of Death Anne Arundel				
Funeral Director	213-26-4634						rthplaca (Stata or Foreign Country) Lryland				
death with the Maryland rms 23e or 28e-f show rmst be notified at	10a. Stata 10b. County										
ar death with the Marylar herrs 23s or 28s-f show her must be notified at		10g. Citizen of What C	Country?								
_ 2 2 2	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 2 Yes 2 No Mark Yes, Giva Year or Dates:	If Yas, spec	dent of Hispanic Origin cify Cuban, Mexican, P 22 No Specify:	? (Specify Yas or No uarto Rican, etc.)	14. Race - Am Black, Wh Specify:					
21215-0020 ed within 72 hours at sparse or than 'natural', or of the Medical Exam	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Decedent's Usua (Giva kind of wo lifa. DO NOT us Barten	ork done during most of se retired)	working		Kind of Business/Industry				
	17. Father's Nama (First, Middle, Last)			18. Mother's Ethe		Ne, Maiden Sumama) Clift					
Ore, Maryland les 1 and 2 abould be file of Health and Mental Hy filem 27 is marked othe of other traumatic event	19a, Informant's Name/Relationship (19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 199 Melody Lane, Arnold, MD 210									
Pages 1 Pages 1 ment of He ant: If Nen uny or oth	20a. Method of Disposition 1 Burial 2 Commation 3 4 Donation 5 Other (Specific	Removal from State	Place of Disposition (Nar cematary, crematory or of Metro Crem	other place)	Jนใช้งา9 2000		Location - City or Town, Stata altimore, MD				
Demit Depart Import any in	22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146										
Physician /Medical	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, show or heart feitura. List only one cause on each line. Approximate Interval Batwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of):										
in the second	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
the atter	Part II. Other significant conditions of	ontributing to death but not re-	23b. Did	3b. Did tobacco use contribute to the cause of death							
, # 80 5		24a. Was		Probably 4 Unknow Wara autopsy findings available prior to completion of cause							
- F 2 2 0					10	Yes 2 Kino	of death? 1 ☐ Yes 2 ☐ No				
delan: The contificate rector, pag		Hospitel: Other:									
4 5 P		28a. Data of Injury (Month, Day Year)	RER/Outpatient 3 DC 28b. Time of Injury		5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred						
To the Hospital or Attanding P within 24 hours effer deeth. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	be on Place of him. At how from short factor, Win. 201 Location (Street and Number or Durel Doub Murch									
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To the within To the comp	29b. Signature and title of certifier	Illen Mi	290	C. License number	8	29d. Data signed (Month, Day, Year) 7-16-2000 ei, Ald 21401					
	30. Nama and address of person who	completed causa of death (Item	m 23a) (Type, Print) al PKLy H	low, Ar	wejou	dis:	21401				
State Registrar	31. Data filed (Month, Day, Year)	32. Registrar's Sign		boules							

JUL 18 2000 - Territoria

CATHERINE	Vital Records, P.(
HELEN	of Vital
NAME:	Division

	State of Maryland / Department of Health and N Certificate of Death	Reg.	UU	24607						
Physician /Medical	1. Decedent's Name (First, Middle, Last) Helen Catharine Lavin	2. Date of Death Month JULY 06, 2000 Year 12:20AM								
Examiner	4a Fecility Neme (## not institution, give street and number) St. Mary 's Hospital 5 Social Security Number 6 Sex 7 Ana (In vrs. lest hirthday) If Under 1 Year If Under 24 Hrs.	ocation of Death 4c. County of Deel OWN St. M.		ary's						
Funeral Director	5. Social Security Number 6. Sex 1 Months 2 F 7. Age (In yrs. last birthday) 1 ft Under 1 Year 1 ft Under 24 Hrs. 4 Months 2 Months 2 Min. 4 Min. 4 Min	8. Deta of Birth (Month, Day, Yea July 27,	ar) 9. Birth Con 1914 Peni	9. Birthplaca (State or Foreign Country) 1. Pennsylvania						
death with the Menyland me 23e or 28e-f show crast be notified at neral Director	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☒ No						
vith the Menylar or 28e-f ahov be notified	Maryland St. Mary's Avenue	1.0-	03/							
with Dir	10e. Street and Number 10f. Zip Code	100.	Citizen of What Cou	untry r						
offer death were the constitutions of the constitution of the constitutions of the constituti	21725 Oscar Hayden Road 20609 11. Meritel Stetus 12. Wes Decedent Ever In U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Slift Yes, specify Cuben, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	ican Indien,						
urs effer L', or the	1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Detes:	o Rican, etc.)	Specify:	hite						
121215-002 led within 72 hours tygiene. The Marker Ent. The Marker Ent. Completed by	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work		. Kind of Business/I	ndustry						
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land lid be fill ked out ic even	Patrick Joseph Lavin Cathari									
Maryla d 2 should th and Men 7 Is marke traumatic	1	ral Route Number, City or Town, Stete, Zip Code)								
	Marquerite M. Lavin (Sister) 22680 Cedar Lane Cour	t, Leonard	dtown, Man	ryland 20650						
altimore, mit. Peges 1 er partment of Nee portant: If Nem 2 y Injury or other 25.	20a. Method of Disposition 1 Buriel 2 Comment 3 Removel from State 20b. Plece of Disposition (Name of cemetery, crematory or other piece)	Dete 20c	Location - City or 1	Town, Sfate						
Peges nent of I		7/7/2000 Ale	Virginia							
Balti permit. Departi Importa any ink	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardine									
m go = a a	Michael Hardiner P.O. box 270, Ieon									
	23a Pert 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac shock, or heart failure. List only one cause on each line.	or respiretory errest,	-	Approximete Interval Between						
Physician /Medical	Immediate Cause (Final disease or condition									
Examiner										
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owecuted in and inal-transit	Sequentially list conditions. Due to (or as a consequence of):									
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8760, sete be execut the buriel-trand dical Exam	Cause (Disease or injury that initiated events Due to (or es e consequenca of):									
Box 6 eath certiful attending for use as										
I Records, P.O. Box 6 The law requires that the death certific title has been signed by the attending page 2 should be detached for use as Completed by Physician/Mee	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.	23b. Did tobac	co use contribute	to the cause of death?						
dS, P.O. I		1 🗆 Yee	1 Yes 2 No 3 Probably 4 Unknown							
Vital Records, sician: The law requires th certificate has been signed inector, page 2 should be d Be Completed by		24a. Wes en eu	utoney 24h V	Vere eutopsy findings						
cord v requir been si should		performed	17	veileble prior to completion of cause						
al Record The law requir The law been s page 2 should Completed		400	11	of death?						
	25. Was case referred to medical 26 Place of Dea	1 Yes	2 No 1	Yas 20 No						
of Vita Physician: this certific ral director,	examiner?	th (Check only ona) ome 5 □ Residence 6 □ Othar (Specify)								
On of ling Phys. After this funeral di	27. Menger of Death 28e. Data of Injury 28b. Time of 28c. Injury at		Bd. Describe how injury occurred Bd. Location (Street and Number or Rural Route Numb City or Town, State)							
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Division of the or Attending P rs after death. al Director: After ted in by the funeration: Certification:	3 ☐ Suicide 6 ☐ Could not be detarmined 28e. Place of Injury - At home, ferm, streat, fectory, offica building, atc. (Specify)									
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n 24 houpl n 24 hound ne Funer pletely fill edical	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, daeth occurred et the fima, data end place, and dua to the causa(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the tima, data and place, and dua to the causa(s) end menner stated.									
To the com	29b. Signatura end title of certifier 29c. License number		29d. Date signed (Month, Day, Year)							
	1 1 Jan 40mb 114285		7-6-0	0						
7	30. Name end eddress of person who completed cause of deeth (Itam 23e) (Type, Print) DR. WILLIAM D. BOYD II LEONARDTOWN, MD. 20650									
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture									
State Registrar	JUL 0 7 2000 Serve G. Sparks									
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dale of Death 3. Tima of Death July 1, 2000 5:55 AM Gideon Lee 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 37095 Dixie Lyon Road Mechanicsville St. Mary's If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months Days 1⊠M 2□ F Yrs. 32 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 21 No St. Mary's Mechanicsville 10f. Zip Code 10g. Citizen of Whal Country? 37095 Dixie Lyon Road 20659 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 153 Never Married 2 Married If Yes, Giva Year or Dates: 1 Yas 2 No Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Mary Daniel Lee Armenda Yoder 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20659 19a. Informant's Name/Relationship (Type, Print) 37095 Dixie Lyon Road, Mechanicsville, Maryland Gideon D. Lee (Father) 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Hertzler Cemetery 17/4/2000 Mechanicsville, Maryland 22. Name and Address of Facility.
Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Lion P.O. Box 270, Leonardtown, Maryland 20650 Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or heart failura. List only one cause on each line. Approximata Interval Batween Onsat and Death nom licule Due to (or as a consequence of Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

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Box 68760

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Division of VItal or Attanding Physician: Examiner

Physician/Medicai

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permit. Page Department of Important: if any Injury or page.

Physician

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Examiner

Funeral

Director

28a-f show

Director

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by

Completed

Pages 1 and 2 should be illed within 72 hours after death with the Marylar nant of Health and Mental Hygiena. Int. If item 27 is marked other than "natural", or items 23s or 28s-1 show ary or other traumatic avant, the Medical Examination and itself as

Baltimore, Maryland 21215-0020

the Maryland

Simon

5. Social Security Number

217-19-8171

Usual Residence of Deceder

10a. Stata

Maryland

7th Grade

Gideon

20a. Method of Disposition

10e. Street and Number

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediata Cause (Final disease or condition resulting in death)

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 20 No

24b. Wara autopsy findings available prior to completion of cause of death? NA 2□ No ¥ 1 ☐ Yas

25. Was case referred to medical axaminer? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Describe how injury occurred

27. Manner of Death 1 Neturat 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only

4 Homicide

Terrifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) end menner as stated.

2 | Hedical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title

30. Nama and audity in of person who comple

29c. Licensa number

Hollywood, Maryland 20636

29d. Dala signed (Month, Day, Year)

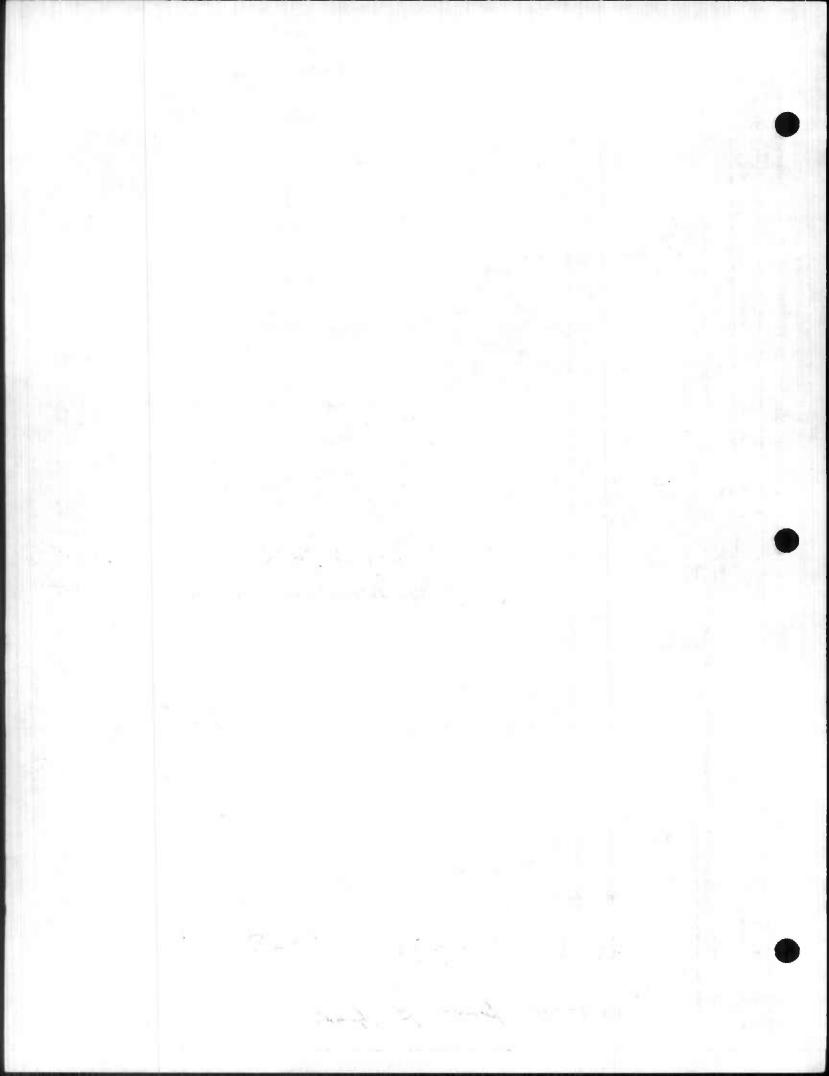
State Registrar

Jarboe, P. MD James. 31. Data filed M outh, Day, Year) 0 7 2000 JUL

32. Registrar's Signatura

d cause of death (Item 23a) (Type, Print)

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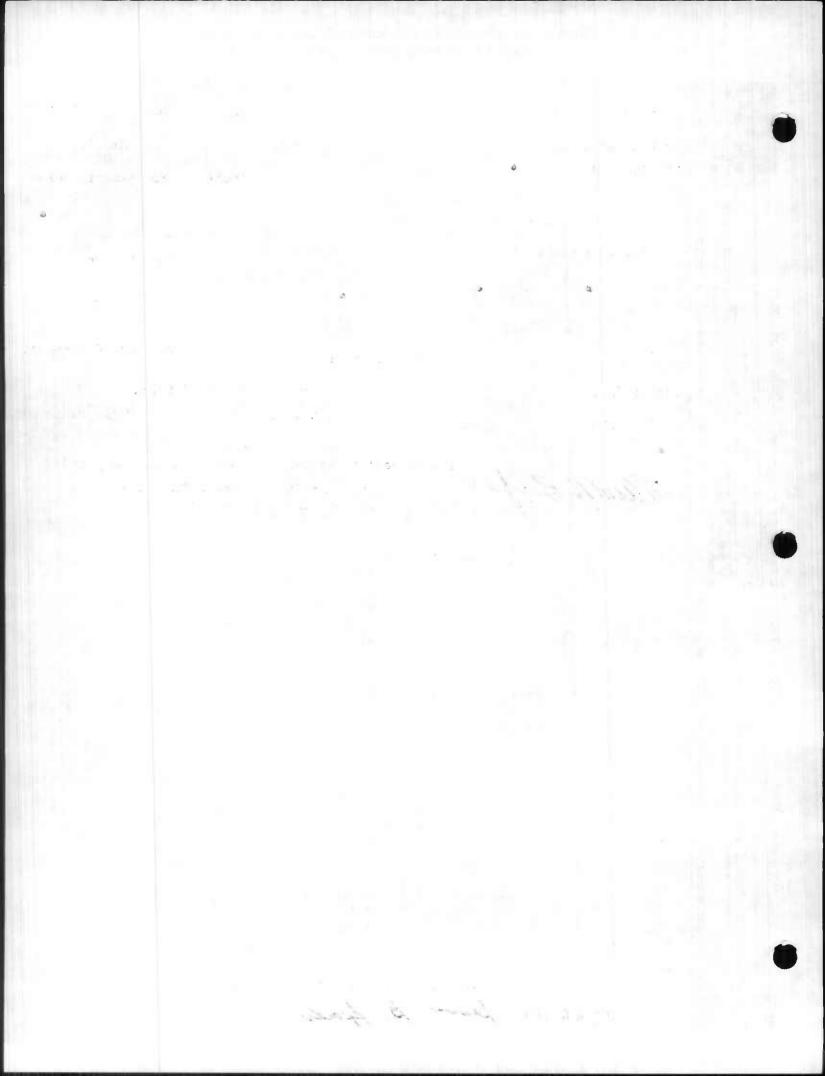


State of Maryland / Department of Health and Mental Hygiene

			Certifi	cate of	Death	Re	g. No.	24000						
	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death						
Physician /Medical	Margaret	Evelyn	Long			July 3,	Day Year	1:00 AM						
Examiner	4a Facility Name (If not institution, give :	street and number)		- 4	lb. City, Town, or Lo		4c. County of De	eth						
	41695 New Market	Turner Road			Mechanics	ville	St.	Mary's						
Funeral	5. Social Security Number 6. Sec		MELON ENTERPRETATION OF THE PERSON OF THE PE	Under 1 Year	If Under 24 Hrs.			irthplece (Stete or Forei						
Director	218-14-3209	M 2⊠F 79	Yrs. Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day, October 2	, 1920 Ma	ryland						
ð m	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Locatio	n				10d. Inside City Limi						
natural, or items 23a or 28a-f ahow deal Examiner must be notified at steed by Funeral Director	Maryland St. Man	cv's M	echanics	zille.				1 ☐ Yes 2⊠N						
180 PE	10e. Street and Number	7		Of. Zip Code		10	g. Citizen of Whet (Country?						
98	41695 New Market	Gurner Road	127000	206	59		USA							
10 F		12. Was Decedent Ever in U.	,S. 13. Was		ispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No-		nerican Indien,						
al', or items 23a or 28a-fa territet must be nodfaet by Funeral Director	1 Never Married 2 Married 3 🖾 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		s, specify Cuba ∕es 2⊠No		Rican, etc.)	Bleck, Wh	nite, etc. Thite						
her than "natural", nt. the Mindeal En-		cation	16a. Decedent's	Usual Occup	ation	10	6b. Kind of Busines	s/Industry						
than 'n	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind life. DO N	of work done o IOT use retired	during most of work f)	ng								
Hygiena. ther than and, the M	7th Grade	00.000 (1 40.01)	Ho	omemake	r		Own Hor	ne.						
T 8 6 0	17. Father's Name (First, Middle, Last)		4711118		18. Mother's Name	(First, Middle, Ma	aiden Sumeme)							
Mente arked artic av	Joseph Spence	er Cusic			Daisey	Ann	Ada	ams						
2 6 6 1	19e. Informant's Name/Relationship (Type		19b. Mailing Ad	Idress (Street	and Number or Run	I Route Number.	City or Town, State	Zip Code) 20659						
Ith and 27 la m r traum	Charlene Ann Adams						sville, Mary							
If Itam 2 or other	20a. Method of Disposition	20b. P	(Name of			Oc. Location - City of								
ant: If he	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremetory or other place)													
Department of Important: If I any injury or once.		4 Donation 5 Dother (Specify) St. Joseph's Cerretery 7/7/2000 Morganza, Maryland												
any i	21. Sometime of Furnaral Service Licenses 22. Name and Address of Fecility Mattingley-Gardiner Funeral Home, P.A.													
	W WILLEY DAVIN I I - A W													
	P.O. box 270, Leonardtown, Maryland 206 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, into the order tailure. List only one cause on each line.													
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xaminer	disease or condition resulting in death)													
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die the	that initiated events resulting in death) Last	Due to (o	r as a consequenc	e of):										
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the a	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ying cause giv	en in Pert I.	23b. Did tob	acco use contribu	te to the cause of dear						
Phy Phy	Mite so	AXITIC				1) Yes	2 No 3	Probably 4 Unknown						
oe og	0512016	101/3												
should should	Tarren	nt Ilch				24a. Wes en		. Were eutopsy finding aveilable prior to						
pate has been s. page 2 should	- TONKIE	NI LICH	MIC	ATTO	ex	Pononie		completion of cause of death?						
o has						10V-	2010	1 ☐ Yes 2 ☐ No						
cartificate rector, pag	25 Was asso referred to a disal				00 8		1	· L 193 Z L 140						
s cartificate he director, page To Be Com	25. Wes case referred to medical examiner?	iospital:		Oth	26. Place of Deetl	_								
this or all direction To	1 Yes 2 No	1 □ Inpatient 2 □	28b. Time of	LIDON	4 Nursing Ho	me 5 Residen	ce 6 Other (Sp	pecify)						
After Lune	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Work		Lou. Describe 110V	anjury occurred							
rs after death. at Diractor: After t ied in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be		N		Yes 2□No									
irac n by	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, f	actory, office		28f. Location (Stre City or Town,		Rurel Route Number,						
S S S S S S S S S S S S S S S S S S S														
within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Cartifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of my known: On the basis of examinat	wledge, death occi tion and/or investig	urred et the tin pation, in my o	ne, date end place, pinion, deeth occurr	end due to the cau ed et the time, dat	use(s) end menner e end plece, end d	as stated. ue to the ceuse(s)						
Med Med	29b. Signeture and title of certifier	and manner stated.		29c. License	a number	20.	n Data signed #4s	oth Day Veer!						
\$ P 0	250. Signeture and title of certifier					29	d. Date signed (Mo	inii, Day, 1087)						
	KOMEGE	mpleted cause of death (Item Chta, 32. Registrar's Signa		1 23	6206		115100							
	30. Name and address of person who co	npleted cause of death (Item	n 23a) (Type, Print)	0	1 40									
	Kiron M	Chta. 1	Philip	15 can	Med	:col 6	entel	Hollyax						
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture 4	1	,		40 17	16/2.						
Registrar	1111 0 17 200	10 Deneva	[]	Ann V	-1		11/10	60636						

State of Maryland / Department of Health and Mental Hygiene

					Cer	tificat	e of	Death	R	eg. No.	0 24011
		1. Decedent's Neme (First, Middle,	Last)	995	969				2. Dete of Dee Month		3. Time of Deat
/1	ysician Medical caminer	Beverly 4a Fecility Name (If not institution,	Ann give street end numi	Lewis				4b. City, Town, or	July 1.	2000 4c. County	7:40 p.:
	Kammer	49912 Airedele R						Didao		C+	Mary's
Fun	neral	5. Sociel Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under	1 Year Days	Ridge If Under 24 Hrs Hours Min.			Birthplace (State or Fort Country)
Dire		005-30-9790 Usuel Residence of Decedent	1□M 2■F		66 Yrs.	MOTITIS	Days	Hours Will.			Bangor, Main
lend w	10	10e. State 10b. County		10c. Cit	y, Town or Loc	ation					10d. Inside City Lin
Mery sh	tor tor	Maryland St. Ma	ry's		Ridge						1 ☐ Yes 2 €
with the	i Directo	10e. Street and Number 49912 Airedel	e Road			10f. Zip	Code 2068	30		0g. Citizen of W	
leath	Iner must	11. Maritel Stetus	12. Was Deced		,S. 13. W	/as Dece	dent of F	lispanic Origin? (5	Specify Yes or No- to Ricen, etc.)		- American Indian,
5-UUZU 72 hours after death with the Menylend naturel, or thems 23e or 28s-f show	by B	1 Never Married 2 Marrie	Armed Ford 1 Yes 2 If Yes, Give Year or Dat	. No		Yes, spe		en, Mexicen, Puer Specify:	to Ricen, etc.)	Specify:	k, White, etc. White
72 hours	ted te	15. Decedent's	Education		16a. Deced	ent's Usu	el Occup	pation	dina	16b. Kind of Bu	siness/industry
	rt, the Medical	(Specify only highest Elementary/Secondary (0-12)	College (1-4	4or 5+)	life. D	O NOT u	se retire	during most of wo d)	rking	Corrorna	ent Contract
	CO CO	12			Recep	tion	ist	40.40.41.1.41	- 151 A B B B B		
tal H	-	17. Father's Name (First, Middle, L	ast)					18. Mother's Na	me (First, Middle,	Meiden Sumem	9)
should be nd Mantal marked o	To	Alfred Kitty La							Ophelia		
5 W W 3	treumatic	19a. Informant's Name/Reletionsh		1	9750	Address Trin	(Street	Church E	Road, Cha	r, City or Town, .rlotte	Stete, Zip Code) Hall, Maryla
		Brenda Richards 20a. Method of Disposition	Da	ughter	Place of Dispos	ition (Na	ne of		Date	20c Location -	City or Town, State 206
0 0 -	Ban .	1 ■ Burial 2 □ Cremetion			cemetery, crem	etory or o	ther pla	ce)	July 6,		
Demit. Pag Depertment Important: H	Injury	4 Donation 5 Other (Sp.	,	St	. Micha			netery	2000	Ridge,	Maryland
Physic /Med Exam	lical	23a. Part1. Enter the disease, or o shock, or heart failure. List of the disease or condition resulting in death)		erst	Cover			onardtown ng, such as cerdia	n, Maryla c or respiretory an	nd 2065 est,	Approximate Interval Between Onset and Death
	i i										
P P	the burial-transit	Sequentially list conditions	b	Due to (c	or as e consequ	uence of):	_				
tificeta be axecul	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying									
ficeta be an	edical	Ceuse (Disease or injury that Initiated events resulting in deeth) Last	C								
\$ 0	8 2	resulting in deeting East									
death cert	or use		d								
e dea	etached for use a	Pert II. Other significent condition	s contributing to dea	th but not res	ulting in the un	derlying	ause giv	ven in Pert t.	23b. Did to	obacco uaa cor	tributa to the cause of de
as that the igned by th	be detacl by Phy		2012						1 🗆 Y	as 2/A No	3 Probably 4 Unki
he lew requiras he has been sign	2 should				4.5				24e. Was e perfor	en eutopsy med?	24b. Were autopsy findin eveileble prior to completion of cause of deeth?
The I	Page	a south and							1 □ Y	es No	1 ☐ Yes 2 ☐ No
sicien: The	Be (25. Wes cese referred to medicel						26. Plece of De	ath (Check only or	ne)	
	P 5	examiner? 1 Tes 2 No	Hospital:	patient 2	ER/Outpetient	3□ D0	OA Oth	ner: 4 Nursing I	Home 5 Resid	ence 6 Othe	er (Specify)
	led in by the funeral Certification:	27. Manner of Deeth 1 Natural 5 Pending	28e. Date of (Month)	Injury Day Yeer)	28b. Time of Injury	M	28c. Inju	ry et rk? Yes 2 □ No	28d. Describe h	ow Injury occurr	ed
Attending r deeth.	Ical	2 Accident investigation inves	t be 200 Dines	f Injury - At h	ome, ferm, stre				28f. Location (S	treet end Numb	er or Rural Route Number,
5 4 5	in b	4 Homicide determin	building	, etc. (Specif	(y)	101, 100101	y, omoc		City or Tow		
To the Hospital within 24 hours a To the Funerel I	completely filled in by the funeral Medical Certification:	(Check only 2 Medical E	Physician: To the b	is of exemina							nner as stated. and due to the ceuse(s)
thin the	Mec	29b. Signature and title of certifier 29c. License number 2									1 (Month, Dey, Year)
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2		30. Neme and eddress of person w							1	20(10	
1	Ctoto	John Bennett, 31. Date filed (Month, Dey, Year)		The M		10, (ali	cornia, l	naryLand	20019	
P.	State egistrar	1111 06	2000	Senera	19.	1	na.	Val.			



State of Maryland / Department of Health and Mental Hygiene 0 246

					-		Certi	ficate	of	Death			Reg. N	lo.	Comme	4011	
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sician edical miner			LOUIS not institution, giv		er)				4	b. City, To	wn, or Lo	JULY cation of Dec	14,)	7	15PM
minei	ANN	E ARU	INDEL MED	ICAL CEN	TER					ANNAP(OLIS		A	NNE A	ARUND	EL	
ral tor		Security N	1	ex 7. № 2 F	Age (In yrs.			f Under 1 Months	Year Days	If Under:	24 Hrs. Min.	8. Dete of B (Month, L			Coun	iace (State or itry) INGTON	
	Usual Re	sidence of	Decedent			3						NOV.	10,1	920_1			
rai Director	10a. Ste		10b. County	NDEI			or Local	lion							1	0d. Inside City 1 ☐ Yes 2	
Director	MARYI		ANNE ARU	NDEL	EDC	GEWA'	IEK	104 Tin C	ada .				100.0	itizen of V	Mat Caus		Mino
		et end Nur					9.89	10f. Zip C									
Funeral		MA IC	ROAD	12. Wes Decede	ent Ever in U	J,S.	13. Wa	210 s Decede	nt of H	ispanic Orig	gin? (Spe	cify Yes or N			e - Americ	an Indien,	
by Fur			ed 2 Married 4 Divorced	Armed Force 17 Yes 2 If Yes, Give Year or Dete	□ No 194			es, specify Yes 2		Specify:	i, Puerto	Hican, etc.)			WHIT		
ted		(Sner	15. Decadent's Ed			168.	Deceder (Give kir	it's Usual	Occup	ation	t of worki	na	16b.	Kind of Bu	siness/Inc	dustry	
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Be C			LOGAN									LORENC			.0/		
2			me/Reletionship (Type, Print)		19b.	Meiling	Address (Street			I Route Num			State, Zip	Code)	
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age .		h	neral Service Lice ne disease, or com t failure. List only	1/2	6		297	3 SOI	LOMO	os of Facilit	GEOI SLANI	ROAD	EDG			L HOME . 2103	7
dical Examiner	disease resulting	ite Causa (or condition in deeth)		. Re	ng	CC	onseque	ce	~	Toill	ine	,			1	days	25
Medical	I their min	ielly list cor eding to im Enter Unde Disease or Ited events in deeth) I		d	Due to (d	oras a c	onseque	nca of):									
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by Physician/	pr	nem	mag.	emph	18/	ma	2,6	an	CCI	_		1[No.	2□ No	3 Proi	bebly 4□U	Inknown
Completed		PYS	form	SINU							-	24a. Wa	is an aut formed?	topsy	av	ere autopsy fir ailable prior to mpletion of ca death?	
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Be		case refer	ed to medical								of Deetl	(Check only	one)				
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sation: To Be Com	1 10	er of Deetl latural Accident	5 Pending investigation		Injury Day Year)	28b. T	ime of njury	M 280	Wor	y et k? Yes 2 🗆		28d. Describ	e how in	jury occur	red		
Certification:		Suicide Homicide	6 Could not be determined	28e. Placa of building	Injury - At h , etc. (Speci	oma, far	m, stree	t, fectory,	offica			28f. Location City or 7	(Street own, Ste	a <i>nd N</i> umb ate)	er or Rure	al Route Numb	<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>
edicai	29a. Cei (Ch on	eck only	1 Certifying Ph 2 Medical Exam	ysician: To the be niner: On the basi and menner	s of examine	owledge, etion end	deeth o	ccurred at stigation, in	the tin	ne, dete an pinion, dee	d piaca, th occurr	and due to the	e cause e, dete a	(s) end me nd placa,	end due to	teted the cause(s)	
Medical Certification	29b. Sig	neture and	title of certifier			21		100		e number			29d. D	Date signe	d (Month,	Day, Year)	
	30. Name	G)	rgas of person who	@ Min	of death (Iter	m 23a) C	Type Pri		147.	58	JULY 17,2000						
									AVE	SIIT'	TE 40	OI AN	NAPO	I.TS N	MD 2	1401	
State		filed (Mont	h, Day, Year)	32. Re	istrer's Sign		4		1	11		4.541					
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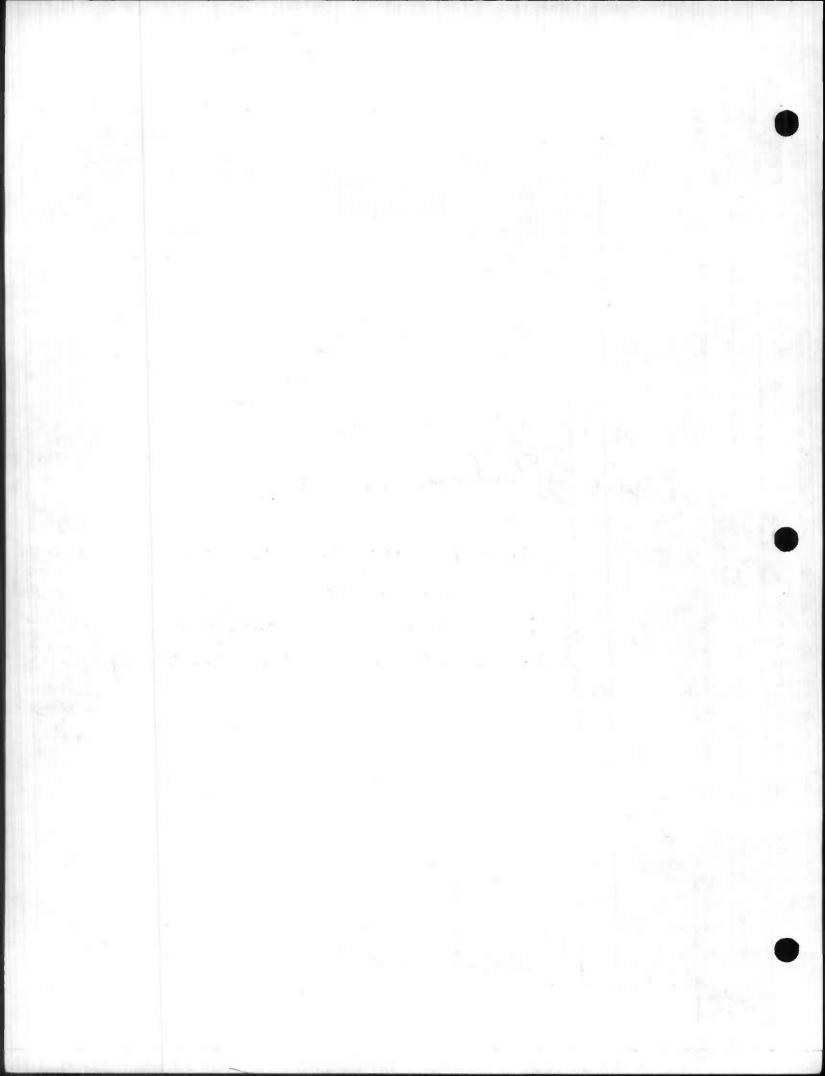
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** JAMES **JOSEPH** LAKE, JR. 23 JULY 2000 5:02P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES LA PLATA CIVISTA MEDICAL CENTER If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec. 9, 1921 Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** Days Hours Months 579-18-5291 78 Dec. Washington, D.C Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits Maryland Charles Waldorf 1 Yes 2 1 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? reast be r 3611 Sassafrass Drive 20602 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Heme 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 🎇 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Owner/Operator Bar/Tavern 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) 89 Pages 1 and 2 should be nent of Health and Mental Kathryn Donnelly James Joseph Lake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnforment's Name/Relationship (Type, Print) nt of Health a : If floom 27 is or other tra Laurent J. Pheulpin/Nephew 3611 Sassafrass Drive, Waldorf, Maryland 20602 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) Disposition

2 Di Cremation 3 Removal from State 20e. Method of D 20c. Location - City or Town, State 1 D Burial Department of Important: If any injury or page. Huntt Crematory 07-25-2000 Waldorf, Maryland 4 □ Donation 5/□ Other (Specify) 21. Signature of Foreral Service Vice 22. Name and Address of Fecility The Huntt Funeral Home, Inc P.O. Box 156, Waldorf, Maryland BROHAWN M00053 MARK G. 20604 mew 23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** /Medical Immediata Cause (Final ICHT MIDDLE 4 disease or condition resulting in death) Examiner Examiner PROINDING Jest. The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initieted events resulting in death) Lest burial-tren Due to (or es e consequence of) and MO 418 Box 68760. +DI2NOCARCINOMA Physician/Medical Dua to (or as a consequence of): 65 yr 8RW use been signed by the atte should be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of 3 Probably Unkny 1 ☐ Yes 2 ☐ No Division of Vital Records, Certification: To Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funerel 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury et Work? After t Netural 5 Pending investigation 1 Yes 2 No death. 2 ☐ Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) within 2 To the F To the 29b. Signature/and title of certified 29c. License number 29d Daffy signed (Menth, Day, Year) D-20629 me and address of pers in who completed cause of death (Item 23a) (Type, Print) WATHEN 11345 PEMBROOKE SQUARE WALDORF MARYLAND 20603 GEORGE H. M.D. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State JUL 2 5 2000 Geneva Registrar



State of Maryland / Department of Health and Mental Hygiene

				Otato of h	naryiaria i		tificate			1101111		Reg. No.	1 2	4613	
	Dhysisian	1. Decedent's Nam	ne (First, Middle, Las	st)		Mad					2. Date of Dea		Year	3. Time of Death	
	Physician /Medical	May	Agnes		Milburn	1						4, ^{Day} 2000		3:20 AM	
	Examiner	4a Facility Name ('If not Institution, give	e street and numbe	r)				4b. City, Tow	m, or Loc	cation of Death	4c. County	of Death		
		Bayside	e Care Cei	nter				1	Lexing				Mar	y's	
	Funeral Director	5. Social Security N	180	ex 7. / □ M 2 ☑ F	Age (In yrs. last 86	birthday) Yrs.	If Under 1 Months	Days Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da March 26	, Year) 1914	9. Birthol Count Mar	lace (State or Foreign try) Cyland	
	2 1	Usuel Residence of 10a. State	10b. County		10c. City, To	own or Lo	cation						10	0d. Inside City Limits	
	the Marylar 28e-f show notified at ector			Maraela				De 201	-					1 Yes 2 No	
	or 28e-1 and manufacture of Director	Maryland 10e. Street and Nu		Mary's	1	exin	gton I		<u> </u>			10g. Citizen of V	Mant Course	4-2	
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	a 23		Insor Dir	12. Wes Deceder	t Ever in II C	12 1/				in2 /Cno	oihi Vac or No		e - America	en Indian	
21215-0020	hours after death with the Marylan turns, or flams 23s or 28s-f show at Examiner must be notified at at by Funeral Director	11. Meritel Stetus 1 Never Mari 3 Widowed	ried 2 Married	Armed Force: 1 Yes 2 If Yes, Give Yeer or Detes	No No	1	Yes, specif		Specify:	Puerto F	cify Yes or No- Rican, etc.)		k, White, e	etc.	
2-0	led within 72 ho ygiene, wer than "naturn it, the Medical Completed	/Sne	15. Decedent'a Ed	fucation	1	6a. Deced	ient's Usual	Occup	ation duning most	of workin	20	16b. Kind of Bu	siness/Ind	lustry	
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yla	Men Men Men To To	Philip	Francis	Young					Mary	Nea	al				
Maryland	da sa da sa	19a. Informant's N	ame/Relationship (Type, Print)								er, City or Town,			
	and and and and and and and and and and	Florence	Young (S	Sister)					Drive,	, Le	xington			and 20653	
ore	or off	20a. Method of Dis		Removal from Stat		e of Dispos etery, crem	sition (Name natory or oth	e of her plac	ce)		Date	20c. Location -	City or To	wn, State	
Ē.	Pag ment ant: It uny o	1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Charles Memorial Gardens 7/19/2000 Leon											rdtov	vn, Maryland	
Baltimore	Depart Depart Import any inj ance	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, a heart failure. List only one cause on each line. Approximate interval Between													
F	Physician /Medical	Immediate Causa (Final disease or condition													
	Examiner	diseese or condition resulting in death)	on	a faile				-					-	3 mo.	
ı.	5	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
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	xacu al-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or es e consequence of):											i		
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287	phys s the	resulting in death)	Last	-	Due to (or es	e consequ	uence of):								
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Division of Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a Completed by Physician/Me										24a. Was perio	en autopsy rmed?	eva	ere autopsy findings aileble prior to impletion of cause death?	
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> :	hysici his ce il direc	examiner?	No	Hospital: 1 Inpa	tient 2 ER/	Outpatien	3[] DOA	A Oth	ner: 4 Nur	sing Hon	ne 5 🗆 Resid	dence 6 Oth	er (Specify	v)	
ion o		27. Manner of Deat 1 Natural 2 Accident	th 5 Pending investigation	28a. Date of In (Month, E	jury 281	b. Time of Injury	M 28	c. fnjur Wor		2		now injury occurr			
Divis	rial or Attending P its after deeth. al Director: After to led in by the funers Certification:	3 Suicide 4 Homicide	6 Could not be determined	, farm, stre	office		2	28f. Location (S City or Tox		er or Rura	il Route Number,				
	within 24 hours after To the Funeral Direct Completely filled in Medical Certif	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the bes infner: On the basis and manner:	of examination										
	To the Com									9c. License number			29d. Date signed (Month, Day, Year)		
			11	9 -	_		-	D	013	8		7-18	.00	0	
		30. Name and addless of person who completed cause of death (Hern 23a) (Type, Print)													
			. Ferwick, N					ltown	n, Maryl	and 2	20650				
	State	31. Dete filed (Mon	th, Day, Year)	32. Regis	trer's Signature				-						
	Registrar	3	UL 18 20	IIII De	merce	4	An.	2 4	1						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		3. No.	24614										
Physician	Decedent's Neme (First, Middle, Last)	2. Deta of Deeth Month	Dey Year	3. Time of Deeth										
/Medical	James Foley Mattingly, Jr.	July 2	, 2000 Year	3:00 PM										
Examiner	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Loc		4c. County of Death											
WE	28075 Old Village Road Mechanics		St. Mary											
Funeral Director	5. Social Sacurity Number 6. Sex 1	8. Date of Birth (Month, Day,) April 27		nplace (State or Foreign intry) aryland										
tand tand	10e. Stete 10b. County 10c. City, Town or Location	1 4		10d. Inside City Limits										
Mary led for	Maryland St. Mary's Mechanicsville			1 ☐ Yas 2 X No										
eath with the Maryla is 23a or 25a-1 shor must be notified at eral Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of Whet Cor	untry?										
Sa or at De	28075 Old Village Road 20659		USA											
swithin 72 hours after death plans. Then "natural", or term 23 the Medical Examiner must completed by Funeral	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yes Give Yaar or Datas:	cify Yes or No- Rican, etc.)	14. Race - Amar Black, White Specify:											
	15. Decedent's Education 16a. Decedent's Usual Occupation	16	6b. Kind of Business/I											
ed within 72 ho yglene. er then *natur t, the Medical.	(Specify only highest grade completed) (Giva kind of work done during most of working life, DO NOT use retired)	19	D. King of Duginous	11000119										
the Man	Elementery/Secondery (0-12) College (1-4or 5+) Public Relations Manage	er I	elephone (Company										
			iddle, Maiden Sumeme)											
id be fi	James Foley Mattingly, Sr. Margaret	D	Doris Abell											
M M M	19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		oute Number, City or Town, State, Zip Code)											
27 is 27 is	Linda E. Long (Daughter) 38700 Foley Mattingly R	oad, Hel												
1.1 at Hash Hemi Other	20e Method of Disposition 20b, Place of Disposition (Neme of		Dc. Location - City or 1											
Int of	1 XBurial 2 Cremation 3 Removal from State Charles Momorial Cardens 7/	7/2000 T	eonardtown	Maryland										
or the part of the	4 Donation 5 Other (Specify) Charles Memorial Gardens 7/7/2000 Leonardtown, Maryle of Funeral Service Licanses (Seculty) 22. Name and Address of Fecility.													
Deput suppose	21. Signature of Funeral Service Licanses 22. Name and Address of Fecility. Mattingley—Gardiner Funeral Home, P. J. P.O. Box 270, Leonardtown, Maryland 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,													
ifficate be assecuted g physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or es a consequence of):													
ath cert	d Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of the cause												
as the igner be d		24e. Was an		Obably 4 Unkno										
aw requires been 2 shou		performe	ed?	vailable prior to completion of cause of deeth?										
The late he page		1 ☐ Yes	2 No 1	☐ Yes 2 No										
Physician: The this certificate ral director, page Co	25. Was case referred to medical examiner?	(Check only one,)											
Physic this ceral dire		ne 5 Residen	ce 6 Other (Spec	city)										
Affar th funeral	1 Veturel 5 Pending (Month, Dey Year) Injury Work?	8d. Describe how	v injury occurred											
or Attandate deat Director: in by the	2 Accident investigation M 1 Yes 2 □ No	281. Location (Street and Number or Rural Route Number, City or Town, State)												
Hospi 24 hou Funer etaly fill dical	29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, each occurred and manner stated.													
within 70 the comple	29b. Signature and title of certifie / 29c. License number	290	d. Data signed (Montf	n, Dey, Year)										
P- 5 P- 0	1 mm trung 014285	-	7-1	(17)										
			7-6-	00										
	30. Nama and diddress of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II Leonardtown, Maryla	and 20650	0											
	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	110 Z003(_											
State Registrar	JUL 0 7 2000 Denera G. Soark													

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Please T	ype	Or	Print	in	B	lack	Indel	ible	lnk.	Assure	All	Cople	es Are	e Legible	e

		State of Maryland / Department of Health and Certificate of Death	Re	eg. No.	24615		
	Physician /Medical	1. Decedent's Name (First, Middle, Last) Marie Joan Moore		Day Year), 2000	3. Time of Death 12; 30PM		
	Examiner Funeral Director	St. Mary 's Hospital Leonardt 5. Social Security Number 6. Sex 1 Months Days Hours Min 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min	8. Date of Birth	St. Mary St. Mary Year) 9. Birth Cou 0,1909 Pen			
	ahow dan	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary's St. Mary's City			10d, Inside City Limits 1 ☐ Yes 2 ■ No		
4	or 28a-f	10e. Street and Number 10f. Zip Code		Og. Citizen of What Cou	intry?		
5-0020	us after ocean with the marylan sit, or fleme 23s or 28s-1 show transfor must be notified at by Funeral Director	11. Merital Status 11. Merital Status 11. Never Married 2 Married 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer I) Yes, See II Y		Jnited Stat 14. Race - Ameri Black, White Specify: Wh	can Indian,		
Maryland 21215-0020	mpi du	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work d	orking	16b. Kind of Business/Ir			
pue	ental Hygle ced other c event, n		me (First, Middle, M	Meiden Sumame) Popadines			
Maryia			Jural Route Number, City or Town, Stete, Zip Code)				
	of He	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cametery, cremetory or other place)	July 12,	20c. Location - City or T			
Baitimore,		21. Signature Funeral Solvice Licensee 22. Name end Address of Fecility Brinsfield Funeral Edward N. Brinsfield, Jr. 22955 Hollywood Roa		P.A.	California 20650		
and in		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart leiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Caudia Due to (et as a consequence of): In any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Deeth			
0 2	कें के	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute les 2 Ø No 3 ☐ Pro	to the cause of death?		
I Records, P.	2 should be d		24a. Was er perform	ned?	Vere eutopsy lindings variable prior to ompletion of cause I deeth?		
of Vital	certificate rector, pa	examiner? Hospital: Other	1 ☐ Ye		☐ Yes 2☐ No		
Division of	within 24 hours effer death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	1 Yes 2 No	28f. Location (Street and Number or Rural Route Numb				
Hospital or	n 24 hours eft. Ne Funerei Dipletely filled in	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation and occurred at the time, date and place of examination and occurred at the time, date and place of examination and occurred at the examina		ruse(s) end manner es			
		29b. Signature and title of certifier 29c. License number D 0641 30. Name and address of parson who computed cause of death (Item 23a) (Type, Print)	9 29	9d. Date signed (Month)	, Dey, Year)		
(State Registrar	DR. JAMES JARBOY HOLLYWOOD, MD. 20636 31. Date filed (Month, Day, Year) JUL 0 3 2000 Agents of death (nem 23a) (1996, Print) 32. Registrar's Signature					

W. pronong.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** George Monroe Miller July 2:15PM 11. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Heart Homes at Bay Ridge Annapolis 5. Social Security Number 7. Age (In yrs. last birthdey). 82 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month, Day, Year) March 14, 1918 Birthplece (State or Foreign Country) **Funeral** Deys Hours 10 M 20 F 415-03-6951 Yrs. Tennessee Director Usual Residence of Deceden the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 Is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Exercises must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21401 United States 829 Coxswain Way Funerai 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 land Mentel Hygiene.

Is marked other than "natu Etementary/Secondary (0-12) College (1-4or 5+) Union Official Communications 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Carrick Miller Della Hancock 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Important: If flam 27 Ia n sny Injury or other traun pncs. Mary Miller / Wife 829 Coxswain Way Annapolis, MD 21401 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Ft. Lincoln Crematory July 13,00 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** tage Picks disease Immediate Cause (Finet diseese or condition resulting in death) /Medical 4 ears Examiner Due to (or es a consequence Examiner the attending physician end hed for use as the burial-transit Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of). Box 68760 Physician/Medical thet initieted events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. detached signed by t 1 Yes 2 No 3 Probably 4 Unknown Cancer þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? pega 2 should Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturet death. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Coutd not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by after a 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner steted. edical 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 22028 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7 Crifton Centre after md 21114 Mn 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JUL 1 4 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3:05 4b. City, Town, or Location of Death 4c! County of Deatl Name (If not institution, give street and number Crownsville 7. Age of yrs. last birthday) Birthplace (State or Foreign Country) XIXM 2 F Days Yrs. 220-36-9230 26 1941 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No MARYLAND ANNE ARUNDEL CROWNSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 715 DEFENSE HIGHWAY 21032 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify:BLACK 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BOCO CONSTRUCTION Elementery/Secondary (0-12) College (1-4or 5+) 10th HEAVY EQUIPMENT OPERATOR COMPANY 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumame) REBECCA PRATT THOMAS M. McGHEE SR. 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY McGHEE (WIFE) 837 CIRCLE ROAD SEVERN, MARYLAND 21144 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State LAKEMONT MEM. GARDENS 7/20/00 DAVIDSONVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. D. Leese M00482 arry 821 WEST ST. ANNAPOLIS, MD. 21401 Approximete Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of rtension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): that initiated events resulting in deeth) Last Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 45 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 21 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was gase referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 WYOU 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manufer of Death 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

permit. Pages Department of Important: If it any Injury or o

Physician /Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be incorred at

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Pages 1 and 2 should be nent of Health end Mental

attending physician end for use es the burial-transit that the daath certificata be executed signed by the a The law requires been si page 2 s certificate Physician: this : After this funeral of Physician/Medical Examiner

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1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Certification:

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or Attending death. after

Box 68760, Records, P.O. Division of Vital I Director: A od in by the f within 24 hours after To the Funeral Direc completely filled in by

Registrar

29b. Signature and title of certifie

5 Pending investigation

6 Could not be

29c. License number

Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

21 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

m 23a)-(Type, Print) Jeffrey Briggs MD

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

32. Registrar's Signature JUL 19

State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtificate of	Death		Reg. No.	0 6	-4010			
Dhoo	toton	1. Decedent's Name (First, Middle, La	st)				2. Data of De Month	eath Day	Yaar	3. Tima of Death			
Phys /Me	dical	ROSEMARY WRIGHT					JULY	18, 2000	0	1:50AM			
	niner	4a Facility Name (If not institution, giv				4b. City, Town, or				NEW YORK			
		ANNE ARUNDEL MEI 5. Social Security Number 6. S		In mit in india of a co	If Undar 1 Yea	ANNAPOLI		ANNE A					
Funer Direct			DM ODE	56 Yrs.	Months Days			v. Year)	ARKAN	lace (State or Foreign Itry) ISAS			
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3a o		1752 POINT NO POI	NT DRIVE		21401		100	UNITED S	STATE	ES			
her dea	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Dacedent Evar in U Armed Forces? 1 ☐ Yas 2 ☐ No	I,S. 13.	Was Decedent of If Yes, specify Cu 1☐ Yes 2 X No	Hispanic Orlgin? (S ban, Mexican, Puer	pecify Yes or No to Rican, etc.)	Blac	e - Amarica k, White,	etc.			
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Depa Depa Import	Suce	21. Signature of Finance September (Specify) METOPOLITAN CREMATORY 07-21-00 ALEXANDRIA, 22. Name and Address of Facility GEORGE P. KALAS FUNER 2973 SOLOMONS ISLAND ROAD EDGEWATER,											
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused tha daa one cause on each line.	th. Do not en	nter tha mode of dy	ring, such as cardia	c or respiretory a	rrest,		Approximate Interval Between			
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sician: The certificate irector, pag	Bec	25. Was case referred to medical				26. Place of De	ath (Check only	one)		-1			
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Attending Physic death.		27. Manner of Death 12 Netural 5 Pending 2 Accidant investigation	28e. Dete of Injury (Month, Day Year)	of 28c. Inj W 1[28d. Describe	how injury occurr	ed						
LIVISION C lal or Attending Pt is after death. In Director: After the ed in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined											
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		30. Name and address of person wife	Completed ceuse of death (Ite	7 23a) (Type	Skreet	1	p-1:	MO	214	101			
	State strar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	A.	Soon	h				,			

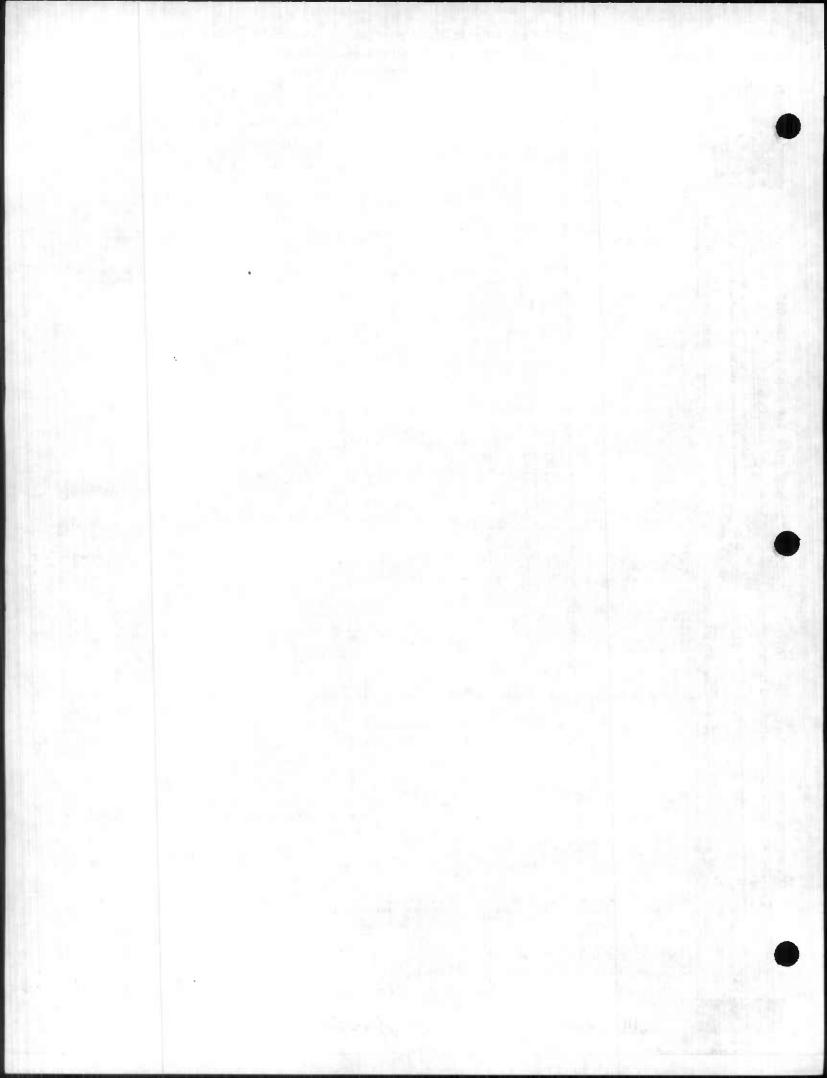
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ı			1. Decedent's Nam	a (First, Middle, La	st)			Maria II		2. Date of Dea		3. Tima o	f Deeth			
	Physici		Betty Ja	ne McMul	1en					Month	/ 8 2 2	vear 4:0	NAU			
	/Medic Examin		4a Facility Neme (/			er)			4b. City, Town, o	Location of Death	4c. County	of Death				
			340 Mark	cet Stree	t				Charlest	own	Cecil					
	Funeral		5. Social Security N		ex 7. □M 2\ F	Age (In yrs.	last birthday)	If Under 1 Ye		. (Month, Day	Year)	9. Birthplace (State Country)	or Foreign			
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	pue M		Usuel Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside C	ity Limits			
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	e filed withing Hygiene. other then		17. Fathar's Name	/First Middle (ast)	1		Postm	aster	18 Mother's No	eme (First, Middle,		Service				
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e,	ges 1 and 2 t of Health If Item 27 I or other trees		20e. Method of Disp		II / Spou	20b.	Plece of Dispo	City or Town, State								
Baltimore,	permit. Peges Department of Important: If Its any Injury or o			Cremetion 3 ☐ 5 ☐ Other (Specify		910				July 19,						
=======================================			4 Donetion 5 Other (Specify) R.A. Ferris Co. Inc. 2000 Pennsylvan 21. Signature of Funeral Sarvice Licensee 22. Neme and Address of Fecility Crouch Funeral Home, 127 South Main													
Ö			1/1/2	1841	110.6							ain Street	,			
			23a. Pert1. Enter t	North East, Maryland 21901 3a. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate												
ME.	Physician		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line.													
4	/Medical		Immediate Cause (Finel disease or condition Renal Call Concer													
	Examiner		resulting in death) a													
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л. О	that the de ad by the detached	hys	Pert il. Other signif	icant conditions c	ontributing to deat	n but not re	suiting in the u	ndenying ceuse	givan in Part I.	1 0		3 Probably 4				
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ř	0 - 0	Completed								1 D Y	es 20 No	1 ☐ Yes 2 ☐] No			
of Vital Records,	certificata rector, pag	BeC	25. Wes casa refer	red to medicel					26. Place of D	eeth (Check only o	ne)					
>	0 0	10	axeminer? 1 ☐ Yes 2 【	No	Hospitel: 1 Inp	atient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 10 Resid	ience 6 Oth	ner (Specify)				
0	After the		27. Mennar of Deat	h 5 ☐ Pending	28a. Dete of (Month,	Injury Day Year)	28b. Time o	f 28c. Ir	njury at Nork?	28d. Describe h	ow injury occur	red				
Division		atic	2 Accident	investigetion	n			M 1	☐Yes 2☐No							
Ž	or Attendiaftar death Director: A	Certification:	3 Suicide 4 Homicide	6 Could not b determined	289. Piece of	Injury - At h	ome, farm, str	reet, fectory, offic	ce	28f. Location (5 City or Tow		ber or Rurel Route Nur	mber,			
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	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)		ninar: On the basi	s of examin-			tima, dete and plany opinion, death oc			anner as stated. and due to the cause((s)			
	the the	Me	29b. Signature and	title of certifier	end manner	Steled.		29c. Lice	ensa number		29d. Data signe	d (Month, Day, Year)				
	F \$ F 8		M. Jorkes, MD D15314 July 19,20													
		-	30. Nama and addr	ass of parent ut	completed cours	of death /#-	m 23e) /Tune	Print)	////		any /	, 2000				
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State of Maryland / Department of Health and Mental Hygiene

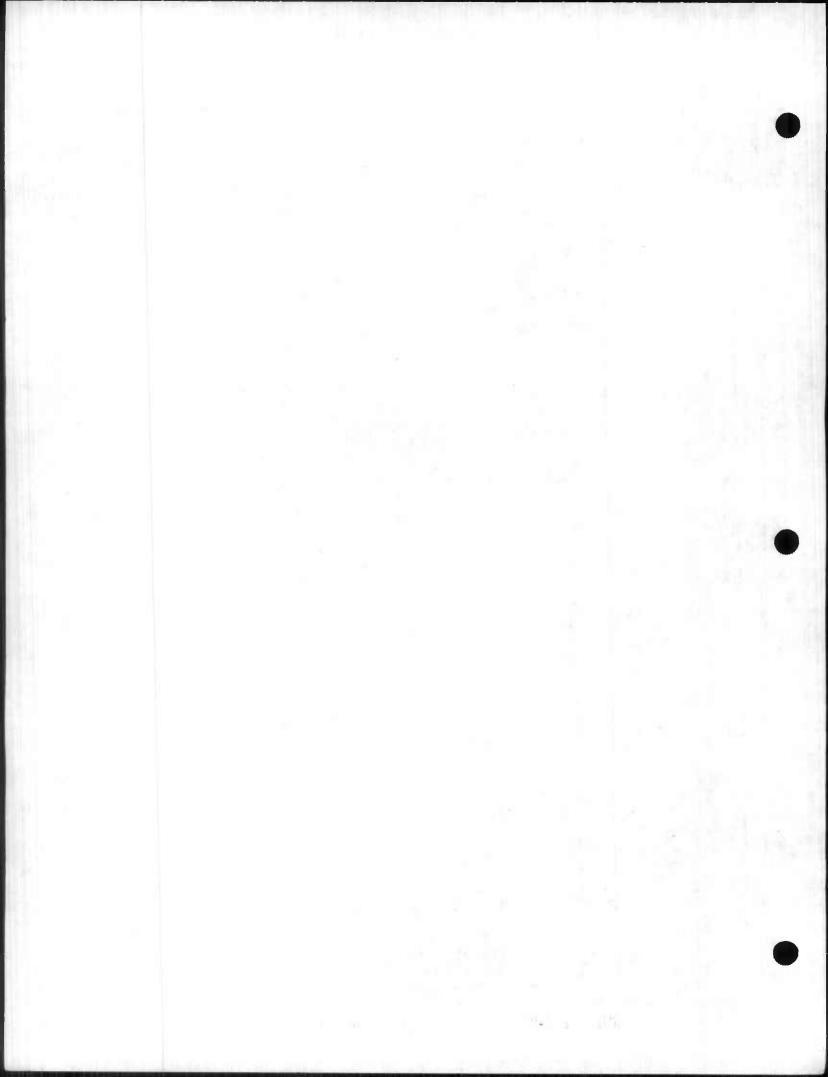
Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 11LLER 8:40pm SHO DNALD 2000 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) **Examiner** ELKTON HOINN MOSPITAL If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1MM 2□ F 119-34-722 Yrs. 55 Director **Usual Residence of Decedent** 10c. City, Town or Location 10d. Inside City Limits 10a. State 10 Yes 2 No De LAWARE AVERTOWN Funeral Director A 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 908 238 434 12. Wes Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Giva Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - Amarican Indian, Bleck, Whita, etc. 11. Marital Status 1 Never Merried 2 Married ò Saltimore, Maryland 21215-0020 1 Yes 2 No Specify WhITR Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OFFICER Olice MyrenFond Poblee 12 18. Mother's Name (First, Middle, Meidan Surneme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental merked erive NARLIE lohn 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Retationship (Type, Print) nt of Health a //II/er WIFE SEATRICE AVERTOUN IA 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition Dete Sterent Thule Burial 2 Cremetion 3 Removel from State 1-20-00 rerex+ thu 4 ☐ Donation 5 ☐ Other (Specify) Cem? 22. Name and Address of Fecility HUNESA (23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MMOCARDIAL MINUTES Lxaminer Due to (or es e consequance of): Physician/Medical Examine MYPERTENSION YOURS Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last 5 yours HYPERLIPIDEMIA Box 68760, Due to (or es e consequence of) P.0. Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings eveileble prior to complation of causa of deeth? 24a, Wes an eutopsy performed? Be Completed page 1 Yes 2 No 1 ☐ Yes 2 No of Vital Physicien: 25. Was case referred to medicat 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 YNo Medical Certification: To Menner of Death 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred or Attending Patter death. Division 1 Netural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted. compietely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 155818 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) HOSPIME 106 BON ST-ELKTON SLICK - UNION ULIE 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar JUL 1 9 2000

State of Maryland / Department of Health and Mental Hygiene

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hysician				Certifi	cate of	Death		Reg. No.						
	1. Decedent's Name (First, Middle, L	ast)					2. Dete of i	Deeth Dey	Year	3. Time of Death				
/Medical	Georgia Josephin	e Moretz					JUL		2000	11:02 A				
xaminer	4e Facility Neme (If not institution, g				-13	4b. City, Town	n, or Location of De	eth 4c. Co	unty of Deeth					
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neral ector	5. Social Security Number 6. 412-44-5253	Sex 7. Ag	e (In yrs. last		Inder 1 Yeer nths Deys		Hrs. 8. Dete of E Min. (Month, December	Sirth Dey, Year)		plece (Stete or Foreign htry) 165566				
	Usuel Residence of Decedent													
rector	Maryland Cecil		Elkto	own or Locatio	n					0d. Inside City Limits 1 ☐ Yes 2 No				
Director	Maryland Cecil		EIKU		f. Zip Code			10g. Citizen	of What Cour	ntry?				
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by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			, specify Cub es 2∭ No		Puerto Rican, etc.)		Black, White, ecity: Whi					
	15. Decedent's I	Education	1	6a. Decedent's	Usuel Occu	petion		16b. Kind	of Business/In					
Completed	(Specify only highest g	rade completed)		(Give kind life. DO N	of work done OT use retire	during most o	f working							
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To	19e. Informent's Name/Relationship (Type, Print) 19e. Informent's Name/Relationship (Type, Print) 19e. Melling Address (Street and Number or Rural Route Number, City or Town, Stell Warren H. Keyes, Jr. / Son 36 Timberlane Drive, North East, Maryl 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 19e. Melling Address (Street and Number or Rural Route Number, City or Town, Stell 20c. Location - City or Town, Stell 20c. Method of Disposition 20c. Location - City or Town, Stell 20c. Method of Disposition 20c. Location - City or Town, Stell 20c. Method of Disposition 20c. Location - City or Town, Stell 20c. Method of Disposition													
			, Maryland 21901 Location - City or Town, Stete											
	20e. Method of Disposition 1 Burial 2 □ Cremetion 3	ion - Oily or Te	wii, ototo											
	4 ☐ Donation 5 ☐ Other (Spec	East,	East, Maryland											
DOCE.	21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Crouch Funeral Home, 127 South Main North East, Maryland 21901													
	Who H.C	rev		Nort	h East	, Mary	land 2190)1						
	23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications that cause	d the death. I	Do not enter the	mode of dy	ing, such es co	erdiac or respiretory	errest,		Approximete Intervet Between				
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al	Immediate Cause (Final	MULTIS	YSTEM	ORGA	N FAI	LURE				DAYS				
r	disease or condition resulting in death) Due to (or es e consequence of):													
je l														
Examiner	Sequentially list conditions,	b	Due to (or es	e consequenc	e of):					DAYS				
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury													
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Physician/P														
hysic	Pert II. Other significant conditions	contributing to death b	ut not resultin	g in the under	ying cause g	iven in Pert I.	23b. D	id tobacco us	e contribute t	o the cause of death?				
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atio	3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Could not be determined 5 Place of Injury - At home, farm, street, fectory, office 5 City or Town, Stefe) 286. Place of Injury - At home, farm, street, fectory, office 6 City or Town, Stefe)								lumber or Rur	al Route Number,				
tificatio	4 Homicide													
Certificatio	4 ☐ Homicide	29a. Certifier (Check only 2) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner as stated.												
eleity filled in by the fur- idical Certification	29a. Certifier 12 Certifying F		f examinetion	end/or investig	gation, in my	opinion, death	Occurred of the fill	ie, dete end pi	ace, end due i	o trie ceuse(s)				
e c	29a. Certifier 10 Certifying F	eminer: On the basis of	f examinetion	end/or investig		nse number	OCCURRED OF THE FILL		igned (Month,					
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completely filled in by the funer Medical Certification:	29a. Certifier (Check only one) 29b. Signeture and title of certifier 30. Name and address of person who	and menner st	f examination eted.),	29c. Licen D 24	nse number		29d. Date s						

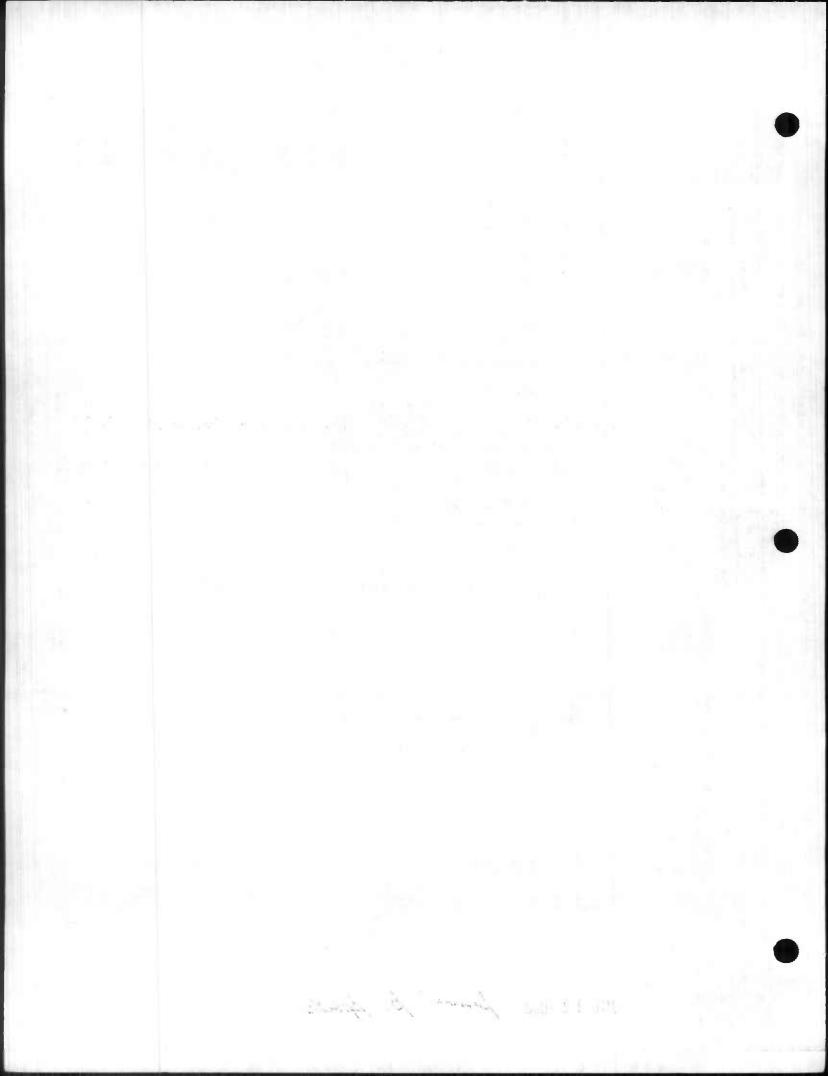


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOSEPH Month Yaar **Physician** 6:23 AM NEUSON JULY 9 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Hours 1⊋M 2□ F Months Days Yrs. Director 73 212-24-4452 March 4, 1927 Maryland Heual Basidence of Decedent deeth with the Maryland 10a Stata 10b County 10c. City, Town or Location 10d Insida City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 □ Yas 25 No Director Maryland St. Mary's Mechanicsville 10e Street and Number 10f Zio Code 10g. Citizen of What Country? 27242 Sandy Acres Lane 20659 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 □ Yes 2 □ No
If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mertel Hyglene.
ant: if item 27 is marked other than "natural", or item any or other traumatic event, the Medical Earth in any or other traumatic event, the Medical Earth in any or other traumatic event, the Medical 1 ☐ Never Married 2 ☑ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Demolition Construction, Co. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be John Nelson Mamie Marie Spears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 559, Mechanicsville, Maryland 20659 Mary Nelson (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 Buriaf 2 Cremation 3 Removal from Stata permit. Page Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 7/14/2000 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each interval Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Cause (Final SEPSIS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner LRITONITIS attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): igned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. p 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Vascular disease 1 Yas 2 No 1 Yas 2 No or Attanding Physician: 25. Was case refarred to medical examiner?

1 Yas 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Watural 5 Pending To the Hospital or Attanding within 24 hours effer death.
To the Funeral Director: Affe completely filled in by the fun 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) Marshus While D45757 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) BACEMO 5505, HORKINS BAYNOW LIECLE MCNABREY Registrar



State of Maryland / Department of Health and Mental Hygiene 📗 🗎 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** CHARLES ELT NICHOLS JULY 17, 2000 10:35 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick
| If Undar 24 Hrs. | Frederick If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1XM 2□ F Days Hours Min. Yrs. 81 Director 404-12-0832 Kentucky Usual Rasidenca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No notified Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen ot What Country? 10e. Street and Number must be n Norma 23a 8122 Cambridge Drive 21704 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: WWII Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 8 Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: P 3 Widowed 4 □ Divorced White be filed within 72 hours tal Hygiene.

I other than "natura event, the Medical E Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondery (0-12) Collega (1-4or 5+) 12 Insurance Agent State Farm Insurance 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other treumstic event DOSS. Fred J. Nichols Johnnie Hays 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat end Number or Rurel Routa Number, City or Town, Stete, Zip Coda) C. Alan Nichols (Son) 4721 Mt. Zion Road, Frederick, MD 21703 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 7/21/00 Frederick, Maryland Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 23a. Pent 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Indiaval Between Onset and Daath **Physician** ASPIRATION PNEUMONIA Immediata Causa (Final disaasa or condition resulting in death) /Medical Examiner Dua to (or as a consaquance of):
CEREBROVASCULAR ACCIDENT Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury physician and as the burial-tran Dua to (or as a consequanca of) 68760 that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANGTO IMMUNOBLASTIC TCELL LYMPHOMA Division of Vital Records. þ 24b. Wara autopsy tindings available prior to complation of cause of daath? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa ratarred to medical 26. Pleca of Deeth (Chack only ona) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To this 27. Mannar of Death 28d. Dascribe how injury occurred spital or Attending Pi nours after death. neral Director: After the filled in by the funera 5 Panding investigation 1 Natural 1 Yas 2 No 2 Accident 28t. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, tarm, straat, factory, offica building, atc. (Specify) 4 Homicida To the Hospital of within 24 hours a To the Funeral D completely filled in the Funeral D completely filled in the Funeral D completely filled in the Funeral D completely filled in the funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end plece, end dua to the cause(s) and mannar es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certitian D46075 30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print) DRIVE #100 FREDERICK MO21702 TOHMSON

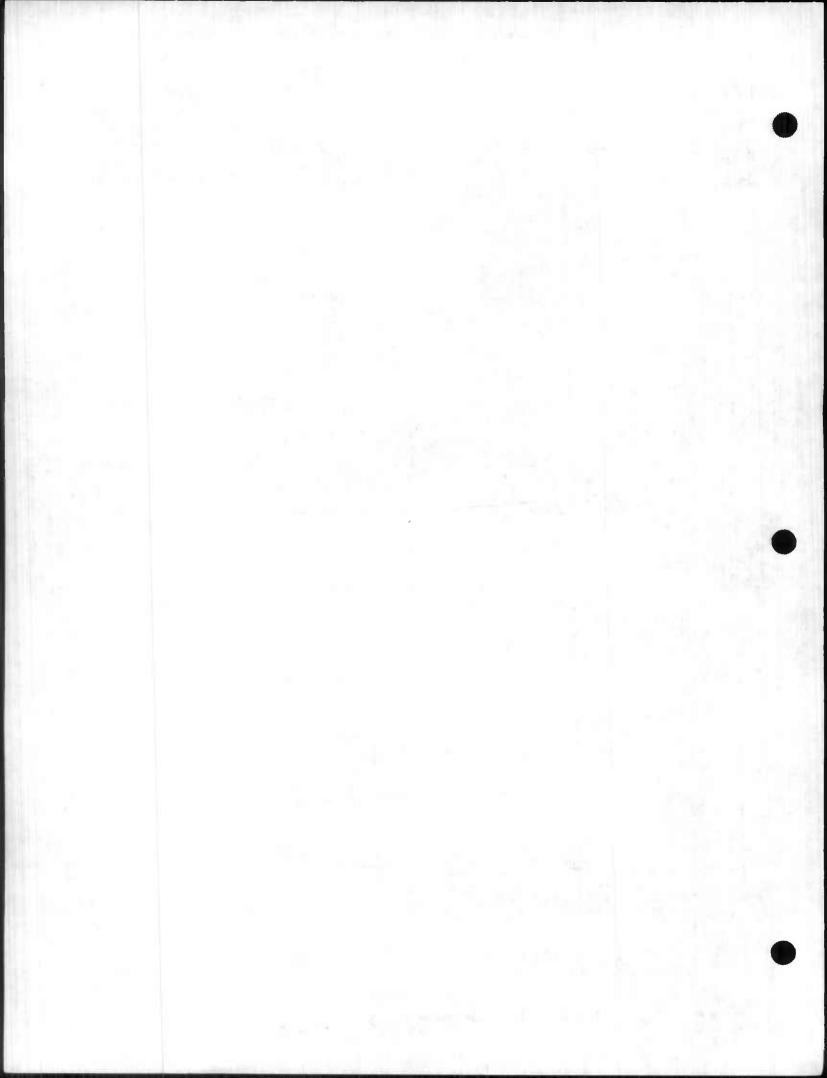
State Registrar 31. Data tiled (Month, Dey 2020) 2 0 2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** Margaret Helene Brady Offutt July 11:45 a.m. 4, 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Tall Timbers
| If Under 24 Hrs. | 8. Date | Mon. | Min. | Mon. 44525 Oliver Drive St. Mary's If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 F Months Devs Yrs. Director 165-14-5134 93 Aug. 4,1906 Pennsylvania Usual Rasidence of Dacedani with the Maryland permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show with Inly or other traumatic event, the Mad on Examined must be notified at DRE. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Tall Timbers Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 44525 Oliver Drive 20690 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ■ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Office Manager Building Contractor 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Lawrence S. Boettner Jennie H. Denkin 19b, Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
44525 Oliver Drive 19a. Informent's Name/Relationship (Type, Print) Margaret V. Walker 20b. Plece of Disposition (Name of cometery, crematory or other place) 20690 Daughter ce of Disposition (Name or netery, crematory or other place) Crema-July, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ■ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Brinsfield-Echols tory 8,2000 | Charlotte Hall, MD 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. Edward 1. Brinsfilld, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20659

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast,

Approximate Approximata Intervel Between Onset end Deeth **Physician** Ten Immediate Ceuse (Finel disease or condition rasulting In daath) /Medical Coronary 1ear Examiner Examiner Hyperten physician and tha burial-transit tha daath cartificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) SS usa 0 signed by tha a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings eveilabla prior to completion of ceuse of daath? 24e. Wes an eutopsy performed? Completed is cartificata has b 1 Yas 2 100 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa refarred to madicel examiner? Be 26. Placa of Daath (Chack only one) Other: 4 Nursing Homa 5 Tasldence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funarai 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Aftar 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation aftar death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) is 24 hours aftar in Funeral Direction blataly filled in b 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the fime, dete end plece, end due to the cause(s) end manner stated. Medical 29a. Certifier within 24 ho To the Fune complataly fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 0 D 5 4346 00 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Typa, Print) Mn 4 24035 Three Notch Road, Hollywood, Maryland 20636

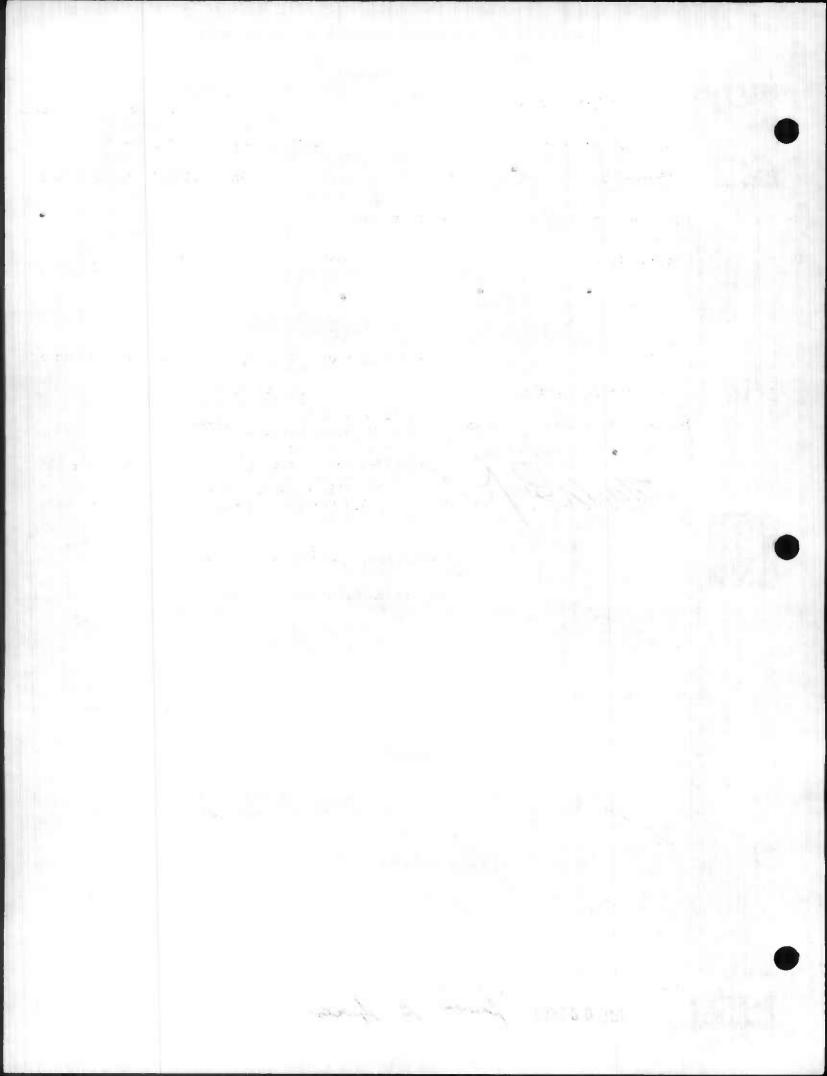
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DHMH 16 Rev 6/95

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Registrar

Chandra B. Sajja, 2 31. Data filed (Month, Day, Yaar) JUL 0 6 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Deeth 1. Decedant's Neme (First, Middle, Last) **Physician** 455 PM Roland D. OTREMBA Jul 2000 /Medical 4a Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL PALTIMORE BALTIMORE If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 6. Sex 1. M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Yrs. 220-20-4714 72 **Director** Jan. 1, 1928 Maryland Usuel Residence of Decedent the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Majo cal Examiner mass be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number U. S. A. 21239 6101 Loch Raven Blud, Apt 303 Funeral 72 hours after death 22. Wes Dacedant Evar in U.S.
Armed Forces?
1 ② Yas 2 ② No
If Yas, Giva
Yaar or Datas: 1955~1957 14. Race - American Indian. Was Decedant of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuben, Maxican, Puerto Rican, atc.) Black, White, etc. 1 Nevar Marriad 2 Married Maryland 21215-0020 1 Yas 2 No Specity: þ 3 Widowad 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16a. Dacedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT use ratired) filed within 7 Hygiena. Elemantary/Sacondary (0-12) College (1-4or 5+) State of Maryland Security Guard 12th Grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) permit. Pages 1 and 2 should be file Dapartment of Health and Mantal Hy Important: If Item 27 is marked ofth any liury or other treumatic event Biole. Agnes Bozek Frank Otremba 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Neme/Ralationship (Type, Print) John E. O'Donnell, Sr. (Step-son) 3508 Royston Avenue, Baltimore, Maryland 21206 Baltimore, 20b. Place of Disposition (Nama of cematary, crametory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 🛛 Cremation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) 07/21/00Baltimore. Maryland Green Mount Crematory 22. Nama and Address of Facility Schimunek Funeral Home Inc. 21. Signatura of Funaral Sarvice Licensee Mart 1. 3331 Brehms Lane, Baltimore, Maryland 21213 Approximete fntarval Batween Onsat and Death 23a. Part1. Enter the disease of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician Immediate Ceusa (Finel disaasa or condition rasulting in death) /Medical ESOPHAGIEAL CANCER Examiner Dua to (or as a consequence of) Examiner death certificate be axecuted burial-transit Sequantially list conditions, if eny, leeding to immediata ceuse. Entar Underlying Cause (Disease or Injury that Initiated avants resulting in death) Lest Dua to (or as a consequence of) physician a s the burial Box 68760. Physician/Medicai Due to (or es a consaquance of) attanding pl signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the ceuse of death? o that tha 1 Yee 2 No 3 Probably 4 € Unknown 0 Division of Vital Records, 2 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy should Completed peen s The law paga 2 cartificata has 1 Yas 20 No 1 Yas No Physician: 25. Was casa rafarrad to medical examiner? 26. Placa of Daath (Chack only one) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 2 1 Tyes 2 No Aftar this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mennar of Death 28b. Tima of 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours aftar death. To the Funeral Director: Aftar ti compiataly filled in by the funera Certification: 1XX Naturel 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacity) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, dete end plece, end due to the causa(s) and manner es steted.

2 Medical Examinar: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of certifie

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Registrar

APHAEZ 31. Date filad (Month, Day, Yaar) JUL 2 0 2000

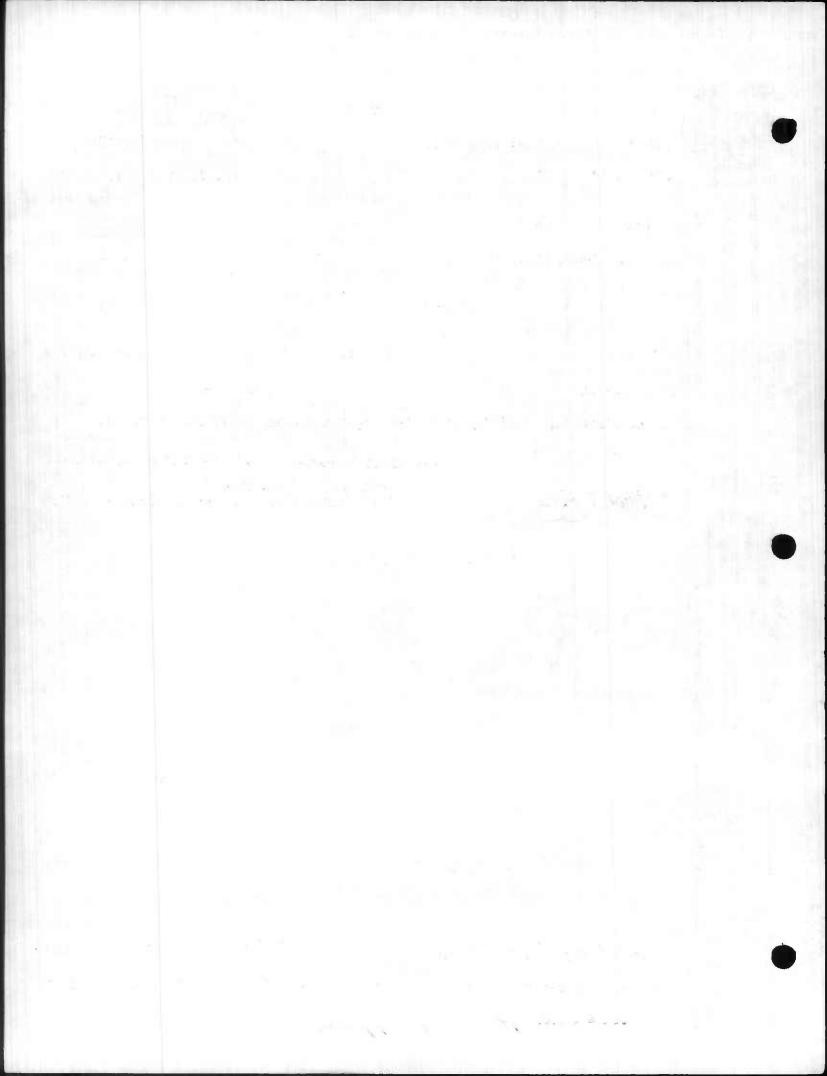
100 30. Neme and address of parson who completed causa of death (Itam 23e) (Type, Print)

Ragistrar's Signature

LOCH RAVEN BLUD

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BALTIMORE MD 21239



State of Maryland / Department of Health and Mental Hygiene

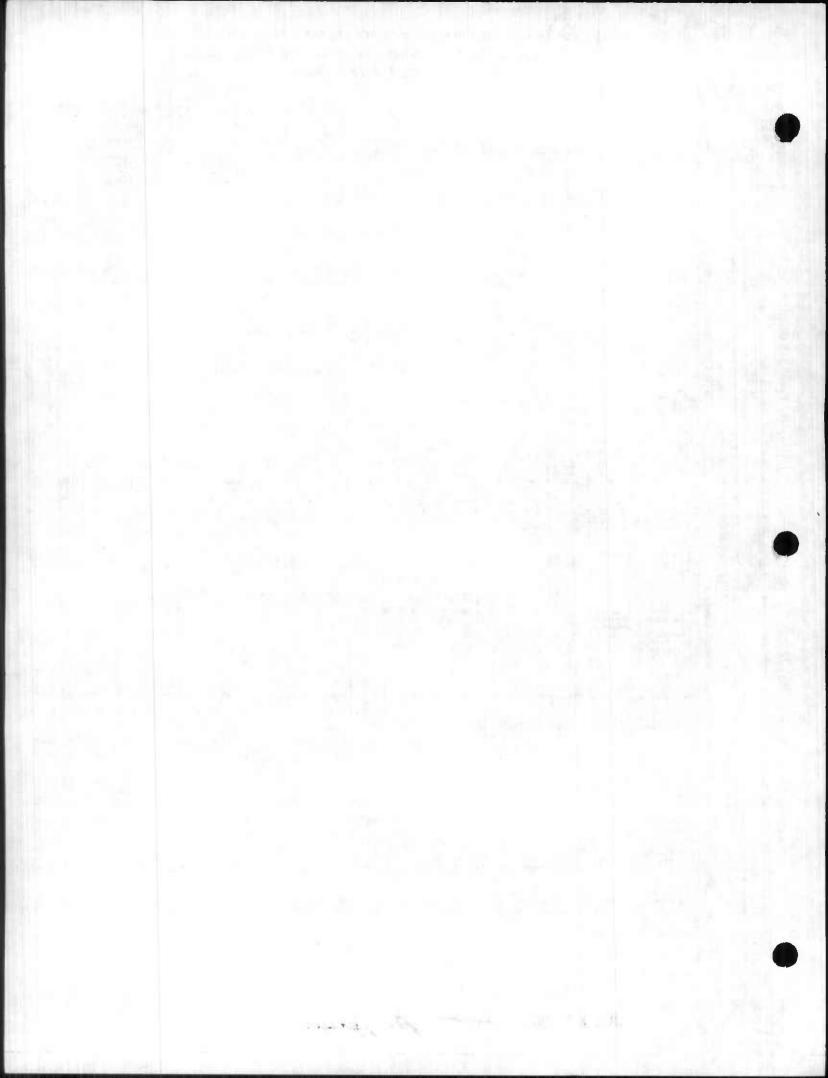
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	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last bin	thday)	If Unde	r 1 Yeer	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9	Birthp	lece (State or Foreign
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altimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		1 XBurial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 7/17/00 ANNAPOLIS														IS. MD.
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



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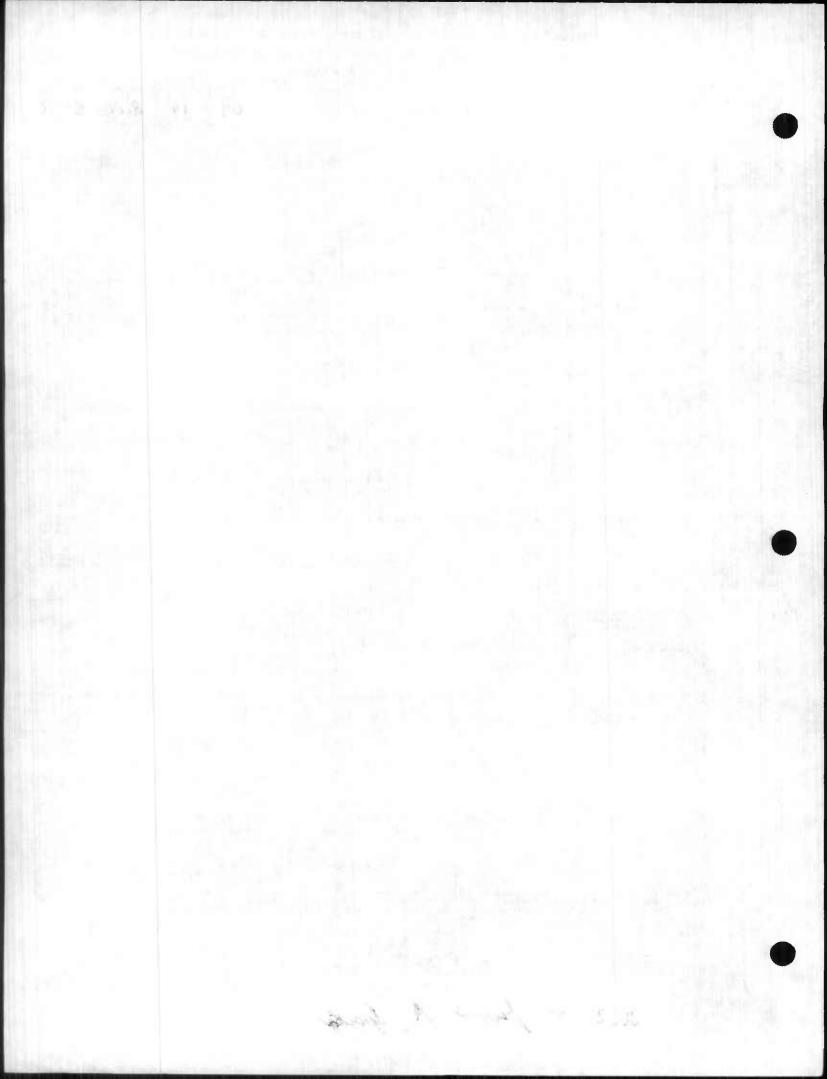
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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E	Pages nent of inf: If it			5 Other (Specify,	Removel from Stete	Ga	rdens	of Fo	ith	Cem.	7/22/00	Baltimo	re, 1	Maryland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic page.		21. Signature of Fu	neral Service Licens	500 / 11		2	2. Neme a	nd Addre	ess of Fecility	al Home,	Tuo		
<u>m</u>	80 = 98		UMU	mala	Kelly		4.73	9705	Belo	ir Rd.	Baltimo	re. MD	21230	6
			23a. Part1. Enter the	ne diseese, or comp rt tailure. List only o	lications that caused	the deeth	n. Do not en	ter the mo	de of dyi	ng, such es car	diac or respiretory	errest,		Approximate Interval Between
	Physician				V									Onset end Deeth
Ş	/Medical Examiner		Immediate Cause (disease or condition resulting in death)	Finel n	CONC		3770	= 4	-	ユナ ド	TILUR	5	1	3 4000
	0		resoning in death)			Due to (o	r es e conse	quence ot)	:					
11	nsit .	an/Medical Examiner			b								1	
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ox 68760,≥	eath centificate be executed attending physician and for use as the burial-transit	Ca	that initieted events		C	Due to (or	es e conse	nuence ot)					1	
68	tificating phy as th	l ed	resulting in death) L	ast		200 10 (0.	00000000	400.100 01,					i	
XO	endir r use	2			d								1	
0.8	dead dead		Pert II. Other eignifi	icant conditions co	ntributing to death b	ut not resu	ulting in the u	underlying	cause gi	ven in Pert I.	23b. Dld	tobacco uae co	ntribute to	o the cause of death?
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ŝ	angine be c	2	100.112										T 0.45 141	A STATE OF THE STATE OF
Records,	requi	916									24e. Wes	s en eutopsy ormed?	ev	ere autopsy tindings relieble prior to empletion of cause
Sec.	2 8	Completed							-24					death?
	: The cate h	3									10	Yes 2 No	10	Yes 2 No
Vita	Physician: The introduction of this certificate he mail director, page	200	25. Wes case refer examiner?		Hospital:				Ot	har	Deeth (Check only			
0	Phys this ral di	0	1 Yes 2 2	70	1 Prinpatie		ER/Outpatie 28b. Time of		OA	4 C IADISII	g Home 5 Res	how injury occur		fy)
on	ding th. After	IIO	1 Maturel 2 Accident	5 Pending investigation	(Month, De)	y Year)	Injury	М	28c. Inju Wo 1 [rk?]Yes 2□No				
Division	or Attending after death. Director: After I in by the fune		3 Suicide	6 Could not be	28e. Plece of Init	ury - At ho	me, term, st	reet, tacto	ry, office				per or Run	el Route Number,
ă	s after al Direction bed in b	Certification:	4 Homicide		building, etc	c. (Specif)	")				City of 10	own, State)		
	de non	edical	29e. Certifier (Check only		rsician: To the best of									
	within 24 h To the Fu completely		one)		and manner ste									
	T V T O	2	29b. Signature and	true of certifier	50	1	- 1	29		se number	60	7/19/00		
			10m	em 10	for	Hoger	nn	0	1)	10		111210	10	
	10				ompleted cause of d	eeth (Item	23e) (Type,	Print)	270	NUTTE	D MA 2	115 4	6 4	nutren
	-		31. Dete filed (Mont		N6 € 000			100	26/8			.5/ 11.		
	State Registra	~	.111			4	19	In	2 16	1				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Yeer **Physician** Month Gertrude M. Parr 2:00 P.M. JULY 16 2000 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Stella Maris Nursing Facility Timonium Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

July 23, 1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2□F 213-16-3642 80 Yrs. Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Maryland Directo Harford Abingdon the Medical Examiner must be notifi 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or flams 23s or 3120 Deer Creek Drive 21009 U.S.A. 12. Was Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify à 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
7th Grade College (1-4or 5+) Floral Shop Owner permit. Pages 1 and 2 aboud be like Department of Health and Mental Hy Important: If item 27 is marked any injury or 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John T. Lutz (Name Unknown) 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. George C. Parr, Jr. (son) 4238 Silver Spring Rd., Perry Hall, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. 7/20/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** bert disess schezmic Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 818 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? P.O. the 1575/ silors signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evailable prior to Completed 24a. Wes an eutopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No this certificate Vital director, Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No of in 24 hours after death.

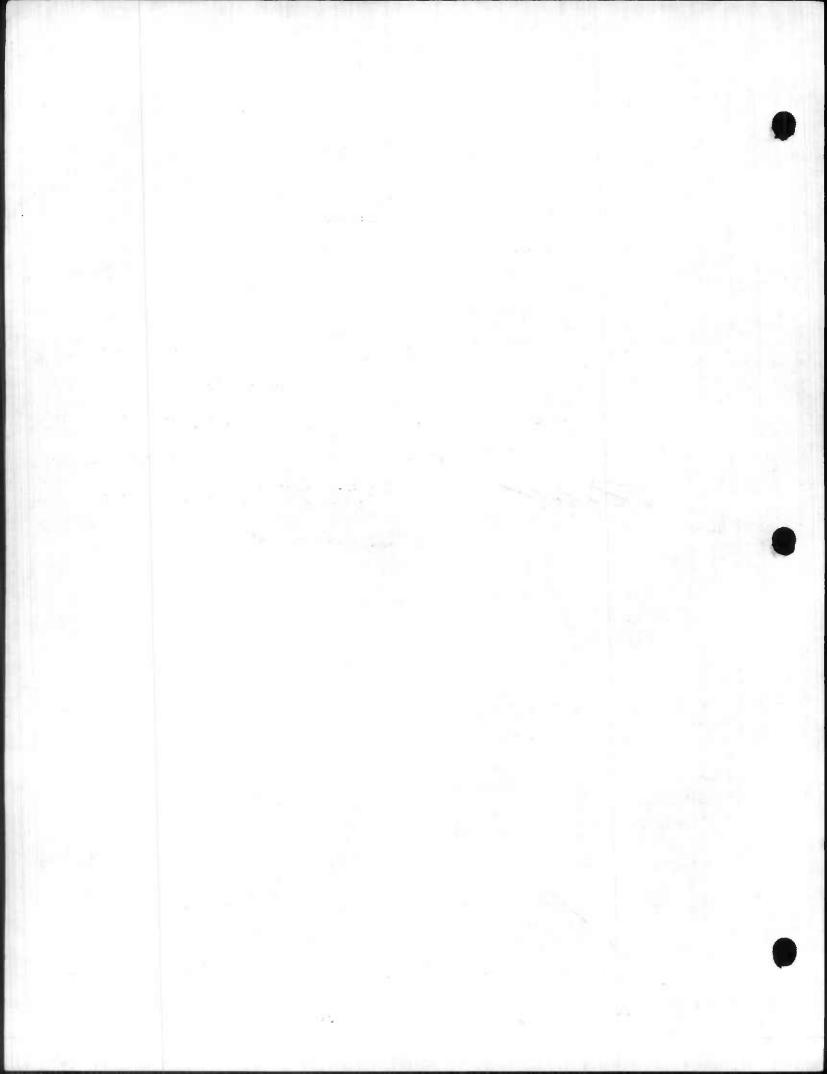
Ne Funeral Director: After this letely filled in but 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 DiNetural 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) ed ceuse of death (Item 23a) (Type, Print) Aulsmap

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Pay, Year) 2000

GERTRUDE

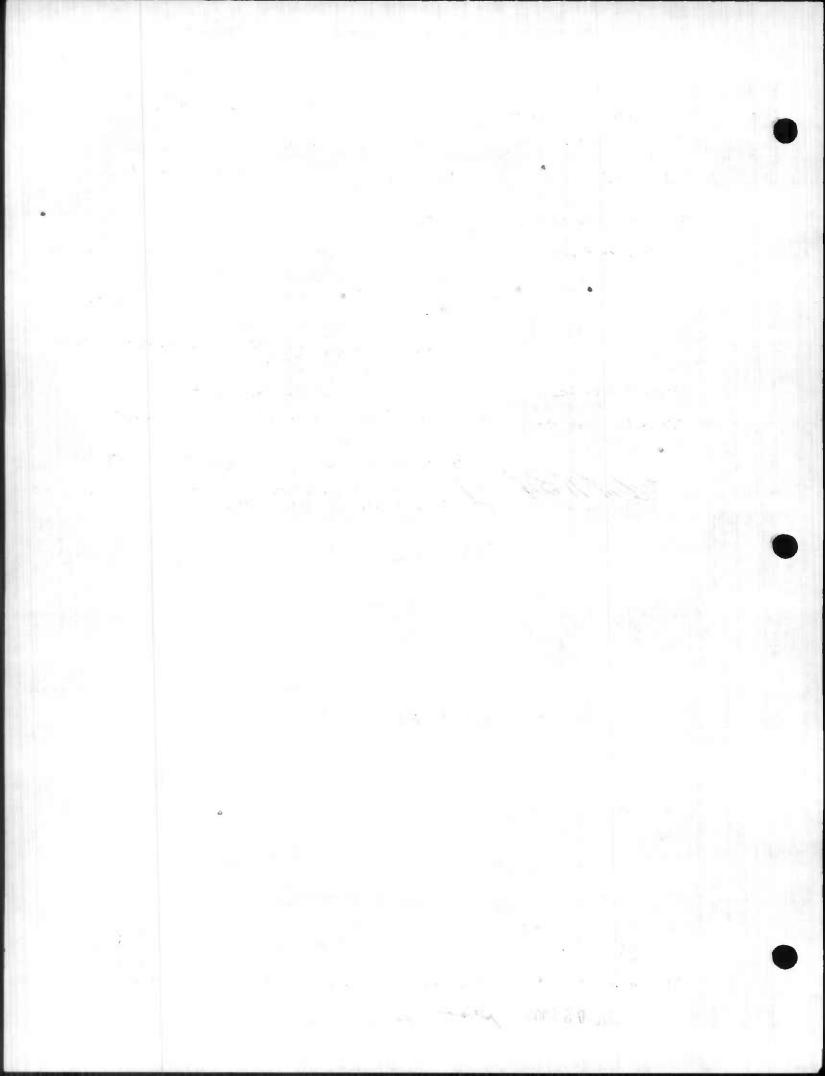
32/Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 00 24630

			Certificate of	Death	Re	g. No.	
	1. Decedent's Name (First, Middle, Last)	ACTION DO NOT	MALE TO THE		2. Date of Death		3. Time of Death
Physicia	Charles Lec	nord	Delen		June :	30°, 2000	5:35 a.m.
/Medica Examine	4a Facility Name (If not institution, give stree 49170 Howard Way	end number)	Raley	4b. City, Town, or Lo		4c. County of	
Funeral Director	5. Social Security Number 6. Sex 1 ■ M	7. Age (In yrs. lest b	virthday) If Under 1 Year Months Days	Ridge If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dev. Jan. 30	St. Mar Year) 1949 M	y'S Birthplace (State or Foreign Country) Lary Land
D .	Usuel Residence of Decedent						
Marylar e-f show	Maryland St. Mary's		wn or Location Ldge				10d. Inside City Limits 1 ☐ Yes 2 ■ No
th with the Ma 23a or 28a-f s	10e. Street and Number 49170 Howard Way		10f. Zip Code 2068	80		og. Citizen of Wh United S	
15-0020 72 hours efter death with the Maryland "natural", or Heme 23a or 28e-f show solical Examiner rount be notified at	1 Never Married 2 Married 1	'as Decadent Ever in U.S. rmed Forces? ■ Yes 2 □ No 1968 Yes, Give ear or Dates: 1974	13. Was Decedent of It Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bleck,	American Indian, White, etc. White
within sne.	15. Decedent's Education (Specify only highest grade continued the Elementary/Secondary (0-12)	16/ opleted) oilege (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire anagement and	during most of work	ing n De	6b. Kind of Busin	t of Navy
be filed tal Hygied d other	17. Fether's Name (First, Middle, Last)			Analyst 18. Mother's Nemo	(First, Middle, M	feiden Sumeme)	100
ylan ylan build be Mental mrked o	James Howard Raley			Edna Cec	elia Sto	nne	
S SEE	19a. Informant's Name/Relationship (Type, F		b. Mailing Address (Street	end Number or Run	el Route Number,	City or Town, St	
	Linda Patricia Raley	Wife	19170 Howard	Way, Ridg	ge, Mary	land 206	80
S Tar	20e. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	ral from State cemet	of Disposition (Neme of ery, cremetory or other pla chae1 s Ceme		1111v 3.	Ridge, M	ty or Town, Stete [aryland]
Baltimo permit. Page Department of Important: If any Injury of	21. Signature of Funeral Service Licenses	4	22. Name and Addre	ess of Facility d Funeral	Home, P.		55 Hollywood
Physician	Edward N. Brinsfi 23a. Parti. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Douse on each line.	o not enter the mode of dyi	ng, such es cardiac	or respiratory arre	1 20030 st,	Approximete Interval Between Onset and Death
/Medical Examiner	tmmediate Cause (Final disease or condition	Melandu	na				lypar
	resulting in death)	Due to (or as a	a consequence of):				
BOX 58/50, leath certificate be executed attending physician and d for use es the burial-transit	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a consequence of):				
that the death cered by the attendir detached for use	Part II. Other significant conditions contribute	ing to death but not resulting	in the underlying cause of	ven in Part t	23b. Did to	bacco use contr	ibute to the cause of death?
by the tached	0	1		voir ii vi ait t.		s 2□No 3	. 1
S, F es that igned b	Bean	metastas	ies				
cord requir been s should					24a. Was ar parform		24b. Were autopsy findings available prior to completion of cause of death?
The law ate has pege 2					1 □ Ye	s 2 No	1 Yes 2 No
Vital Bicien: The certificate	25. Was case referred to medical			26. Plece of Deat	h (Check only one	9)	
Of VIta Physicien: this certific	examiner?	al: 1 Inpatient 2 ER/C	Outpatient 3 DOA Ot	her	me 5 Reside		(Specify)
	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	. Time of Injury Mo	ry at rk?] Yes 2 □ No	28d. Describe ho	w Injury occurred	
DIVISION C tell or Attending P re after death. I Director: After tell led in by the funers	3 Suicide 6 Could not be determined 28	e. Place of tnjury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Str City or Town	reet end Number , Stete)	or Rurel Route Number,
ne Hospi in 24 hou he Funer pletely fil	(Check only 2 Medical Examiner: 0	: To the best of my knowledgen the basis of examination and manner stated.					
Vithi Vithi To the	29b. Signeture and title of certifier		29c. Licens	39979	29	Pd. Date signed ((Month, Dey, Yeer)
in	30. Neme end eddress of person who comple William Kelly, 25500	Point Lookou		nardtown,	Maryland	1 20650	•
State Registra	31. Date filed (Month, Dey, Year) JUL 0 5 2000	32. Registrar's Signature	B. Span	Es .			

DHMH 16 Rev 6/95

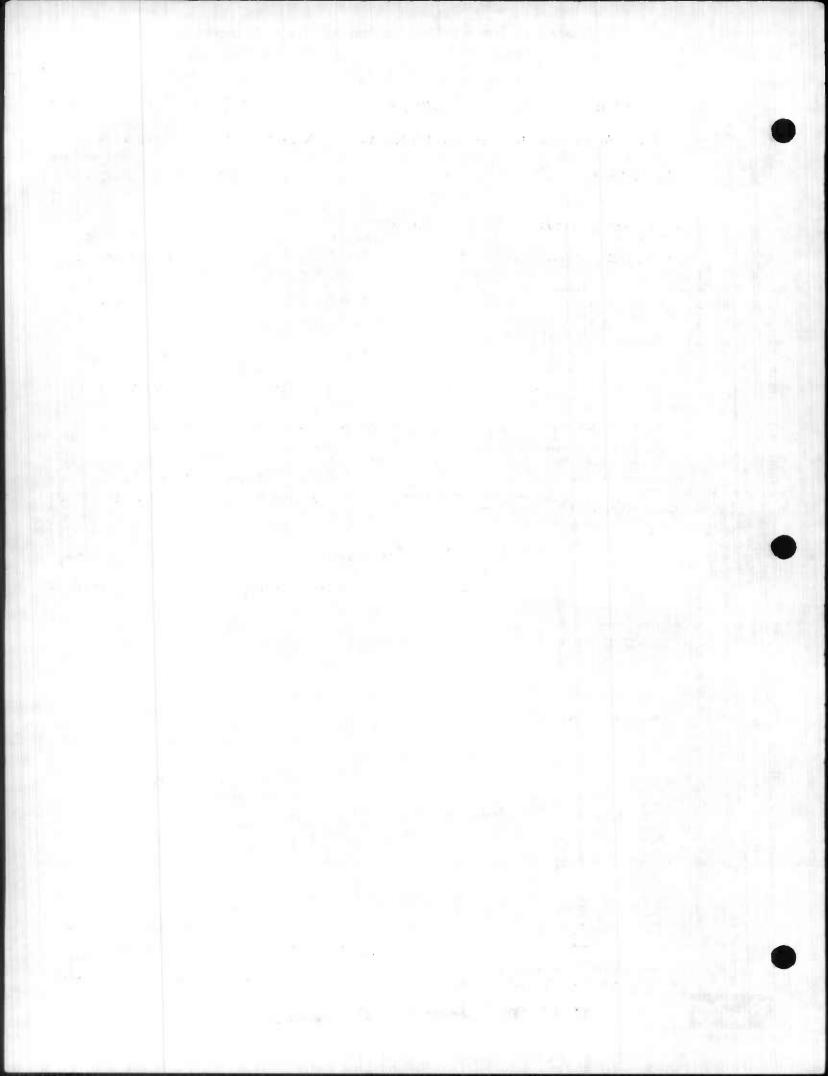


State of Maryland / Department of Health and Mental Hygiene

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Same.	6-02	()	Ü	1

				Cei	tificate	of	Death			Reg. No.		- 1001
Physician /Medical	Decedent's Name (First, Middla, L EDITH	Ast)	RI	TENOU	JR				2. Data of De Month July 19	Day	Year	3. Tima of Death 2:50 P.M
Examiner	4a Fecility Nama (If not institution, g Glade Valley N			ilita	ation				ocation of Daath		of Death	
Funeral Director	5. Social Security Number 6. 212–38–8959 Usual Residanca of Dacedant	Sax M 2□ F	Age (In yrs. las. 86	t birthday) Yrs.	If Under Months	Year Days	If Undar Hours	24 Hrs. Min.	8. Data of Bir (Month, Da Sept. 23	th y, Year) , 1913		nplaca <i>(Steta or Foreignity)</i> yland
death with the Maryland res 23e or 28e-1 show rest to receive at	10a. State 10b. County Maryland Freder	ick	10c. City, 1	own or Lo								10d. insida City Limi Yes 2□ N
or 28	10e. Street and Number				10f. Zip	Coda				10g. Citizan of	What Co	untry?
th wi	1 West Moser Rd	., Apt2	3 B		217	88				Unite	d St	ates
P 2 2	11. Marital Status 1 □ Nevar Married 2 □ Marriad 3 ◯ Widowed 4 □ Divorced	12. Was Daceder Armed Forca 1 Yas 29 If Yas, Give Yaar or Datas	s? No		Was Deced f Yas, spec l ☐ Yas 2	fy Cubi	dispanic Ori an, Maxican Spacify:	gin? (Sp n, Puarto	ecify Yes or No Rican, atc.)		ck, White	
d within 72 hours at giane. If then "natural", or then "natural", or the workel Example Completed by I	15. Decadent's	Education		16e. Deced	dent's Usua	Occup	etion			16b. Kind of 8		
ed within 72 ho or than "nature or than "nature it, the women!	(Specify only highast g Elementary/Secondary (0-12)	rada complated) College (1-4o	v. 5.1	(Give	kind of wor DO NOT us	dona a ratire	during mos d)	t of work	ing			
d within jiane.	7	College (1-40	1 57)	Home	emaker					own	home	
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T Tabe m	Allen	В.	Bortn	er			Lill	ie		Hotz	hapl	.e
d 2 should the and Men 7 is marke traumatic	19a. Informant's Name/Ralationship	(Type, Print)		19b. Maiiir	ng Addrass	(Street	and Numbe	er or Rur	al Routa Numb	er, City or Town	, State, Z	(ip Code)
and 2 is not 27 is nor trau	James M. Riteno	ur/ son		1120	3 Hess	on	Brido	e Ro	I. / Thur	mont, N	m 2	21788
item 27 other tr	20a. Method of Disposition	di, son	20b. Plac	e of Dispo	sition (Nam	e of			Data	20c. Location		
pemii. Pages 1 ar Department of Hea Important: if item; any injury or othe pnce.	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spec	cify)	ta Uti	ca (Cemete	ry			7-24-00	Utica,		
Dan Depariment Importantia	21. Signatura of Funaral Service Lic	enson		22	. Nama and	Addra	iss of Facilit	y St	auffer	Funeral	Hon	ie
4 40 5 6 0	(Barmand	Teler	ear	10	621 Op	oss	umtow	n Pi	ke/ Fre	ederick,	MD	21702
box 66/60, seath certificate be executed attending physician and afor use as the bunal-transit clan/Medical Examiner	disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in death) Last		Dua to (or e Dua to (or e	s a consecut	quance of):		ecide	nt				1 Month
as that the death or gned by the attent be datached for ur by Physician	Pert ii. Other significant conditions	contributing to death	but not rasulti	ng in tha u	ndarlying ca	usa gi	ven in Part i	i.	23b. Did	tobacco use co	ontribute	to the cause of dea
od by the datached datached	h								10	Yes 2 No	3 🗆 Pt	robably 4 Unkn
The law requires that rate has been signed by page 2 should be date.	Hypertension								24a. Was	an autopsy ormed?		Wera autopsy finding available prior to completion of cause
has b											1	of daath?
The land age page									1 🗆	Yas 2 No		1 ☐ Yas 2 ☐ No
vician: The cartificate irector, pag	25. Was casa referred to medical examinar?							a of Dea	th (Check only	ona)		
Physician: this cartifical director.	1 ☐ Yas 2 No	Hospital: 1 🗆 Inpa		NOutpatier		A		ursing H	oma 5□ Rasi	dance 6 DOt	har (Spe	cify)
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bi or Attending P is after death. al Director: After to din by the funers Certification:	3 ☐ Suicide 6 ☐ Could not determine	28a. Place of building,	Injury - At hometic. (Specify)	a, farm, sti	raet, factory	offica			28f. Location (City or To	Straat and Num wn, Stata)	ber or A	ural Routa Numbar,
Outside the Hospital or Attention within 24 hours after deal completely filled in by the Medical Certifical		Physician: To the besing aminer: On the besing and manner	of examinetion									
To the compound of the compoun	29b. Signatura and title of compare				290		se number			29d. Dete sign		h, Dey, Year)
	30. Nama and addrass of parson wh	-	of daeth (Item 2	3a) (Type,	-	L	Itouse	E P	tve,	Freder	rich	MN
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b. Spark



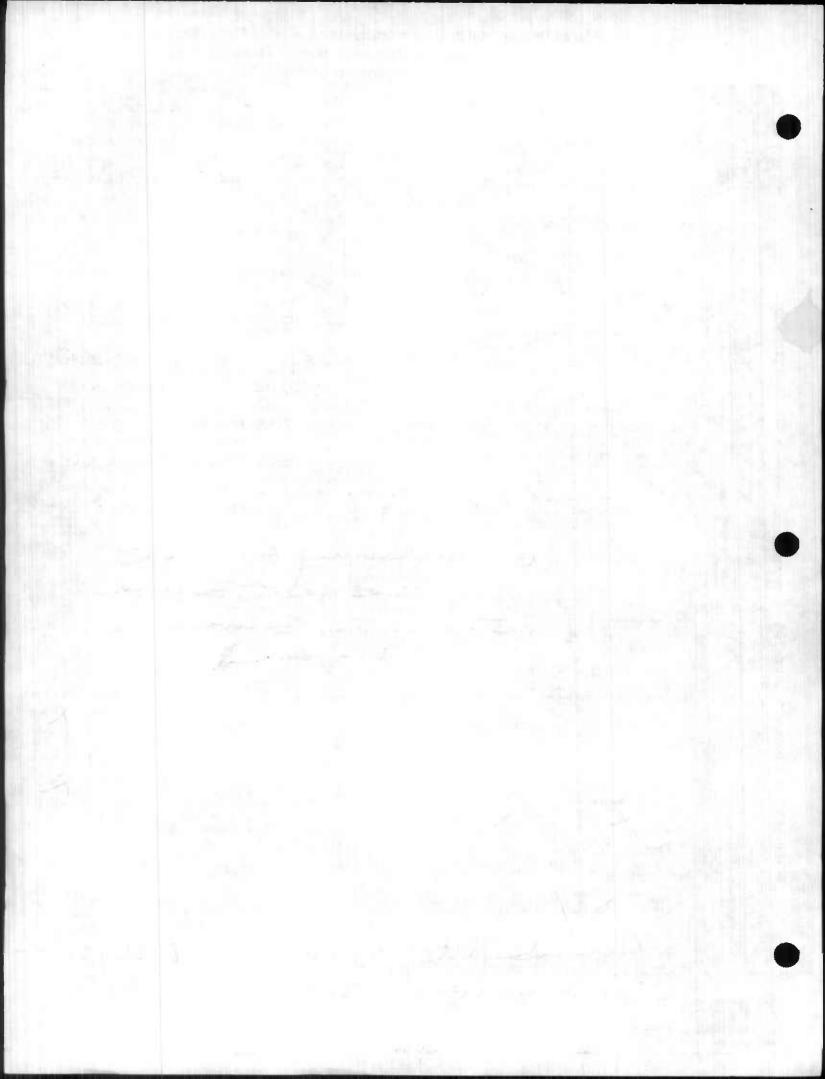
am	nend it	em	26 per verbal response		nd / Department of I Certificate of			eg. No.	0 2	4632
	Physici	20	1. Decedent's Name (First, Middle, La		OFIT	_	2. Date of Deal Month	h Dey	Yeer	3. Time of Death
	/Media	_	BERTHA	UPSHER	REID		JULY	00,00		8:00 P.M.
	Examir	ner	4e Fecility Neme (If not institution, giv			4b. City, Town, or Lo		4c. County		2005
	Funeral Director				Last birthdey) If Under 1 Year Months Days	Hours Min.	8. Dete of Birth (Month, Dey.	Year)	9. Birthpla Counti	ORE ace (Stele or Foreign ry) RGIA
pland	M 10		10e. State 10b. County	10c. C	ity, Town or Location				10	d. Inside City Limits
ne Man	chiffed of	ector	MARYLAND BALTI	MORE	PIKESVIL	LE				1 ☑ Yes 2 ☐ No
with	Sa or 2	I Dir	10e. Street and Number 638 LEAFYDALL	= TERRACE	10f. Zip Code	208	,	Og. Citizen of V		ry?
death	CITAL S	nera	11. Meritel Stetus	12. Wes Decedent Ever in I	99		ecify Yes or No-	14. Raci	e - America	
ours after	Examine	by Fu	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No ff Yes, Give Yeer or Dates:	1 ☐ Yes 2 🕱 No		Hican, etc.)	Specify	k, White, e	ACK
72 h	netu	etec	15. Decedent's En (Specify only highest gre	ducation ede completed)	16e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	petion during most of worki	ing	16b. Kind of Bu	ısiness/Indu	ustry
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Bled	other sent, 1	Ö	17. Father's Neme (First, Middle, Last,)	7,005007	18. Mother's Neme		0/-		.,,,,
old be	Aenta rked tic ev	o Be	JAMES BENT	JAMIN U	PSHER	DELLA	,	KE	ND	RKK
2 sho	and a	_	19a, Intormant's Name/Relationship (19b. Mailing Address (Stree					
and	n 27				\$ 638 LEAFYI	VALE TERRI				
ages 1	I II III		20a. Method of Disposition 1	Removal from Stete	Piace of Disposition (Neme of cemetery, cremetory or other ple			20c. Location -		
D. 1	and.		4 Donation 5 Other (Specifical Signature of Funerel Service Lice)		11	CEMETERY 7				
8	1 1 1		VI	-1/1/11	50SEPH	H. BROWN	U JR. 1	-UNER	AL A	tone
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Phy	ysician		shock, or heert tallure. List only	one cause on each line.	•					Interval Between Onset end Death
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Ex	aminer		resulting in deeth)	a Due to	(or as a consequence of):	1		-0	7	
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ascut	and Il-tran	хап	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to	(or as a consequence of):	00	-	0		
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death	d for	Cla	Pert II. Other significant conditions of	contributing to death but not re	sulting in the underlying cause of	iven in Pert i	23b. Did to	bacco uee co	ntribute to	the cause of death?
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Physician:	certificata rector, pag	Be	25. Wes case referred to medical examiner?	Manadal,		26. Place of Deeth	(Check only or	16)		
hysic	this c	2	1 Yes 2 No		JENOutpetient 3LI DOA		me 5 Reside)
Bu	After	tlon:	27. Menner of Death 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. Injury Wo	ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	red	
or Attac	after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	home, farm, street, fectory, office		28t. Location (S City or Town	treet end Numb n, Stete)	er or Rure	Route Number,
Hospita	within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29e. Certifier (Check only one)	nysician: To the best of my kn niner: On the basis of examin end menner steted.	owledge, deeth occurred et the t etion and/or investigation, in my	ime, date and pleca, opinion, deeth occurr	end due to the c ed at the time, d	euse(s) and ma ate and place,	anner es sta end due to	ated. the cause(s)
To th	Toth	Me	29b. Signeture and title of cartifier	00	O MI Sec. Licen	se number	2	9d. Date rigne	d (Month, E	ley, Year)
			House	- D 15 .1	and DS	1680)	7/2	_6/	00-
			30. Neme end eddress of person who	completed cause of death (Ite	om 23a) (Type, Print)	A .		-11.	7 1	_
			6/1/ Pa-	vos He	aguita	men		21		>
	Sta		31. Dete filed (Month, Dey, Year)	 32. Registrer's Sign 						

DHMH 16 Rev 6/95

State

Registrar

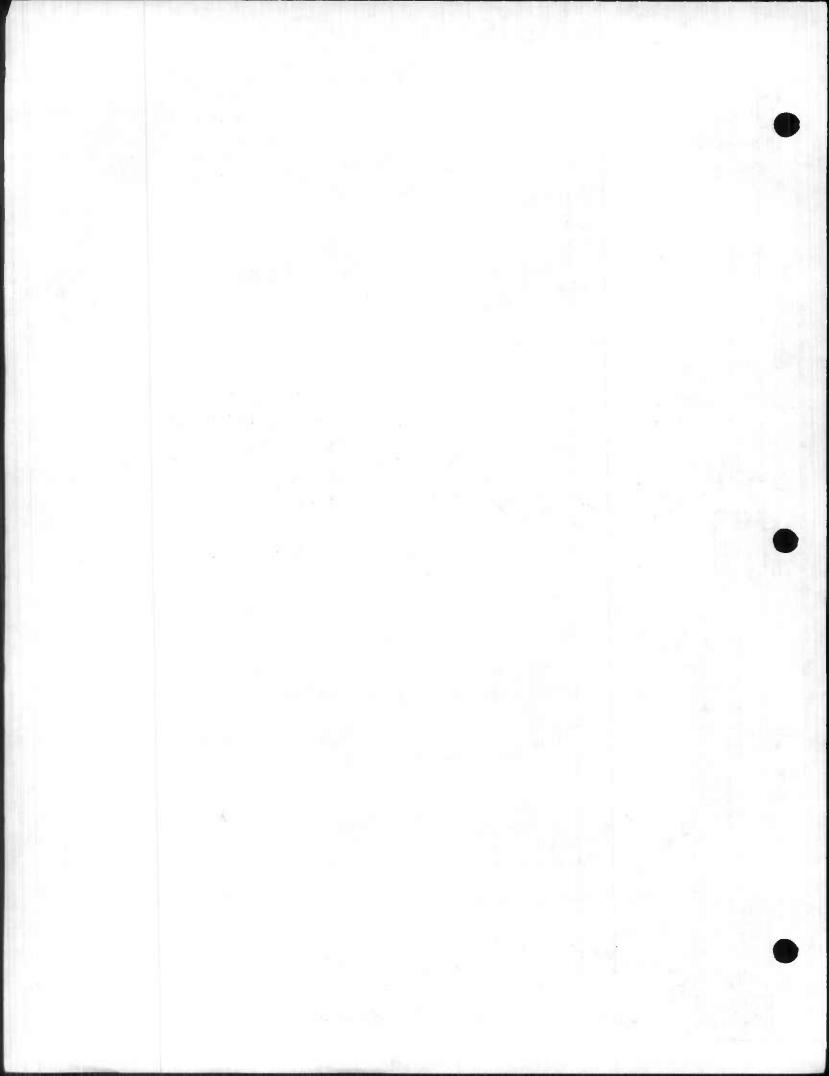
AUG 0 2 2000



State of Maryland / Department of Health and Mental Hygiene

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	U	U	2		0	Ú	-

						Certifica	ate of	Death		Reg. No.		L 70	
			1. Decedent's Nama (First, Middla, Las	st)					2. Data of De	ath	V	3. Tima of	Death
	Physicia /Medic	_	Walter A. Reynold	ls					July	22	2000	6:04	am
	Examin		4a Facility Name (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County	of Death		
4			100 Woody Brown R	Road				Rising	Sun	Ce	ecil		
	Funeral		5. Social Security Number 6. S		rs. last bir	rthday) If Und Month	ler 1 Years	If Under 24 Hr	s. 8 Data of Bir	th		laca (Stata or	r Foraign
н	Director		218-32-8525	M 2DF	64	Yrs.	Julys	TIOUIS MIN	Mar. 2	, 1936	Mari	iland	
	р ,		Usual Residence of Decedent 10s. State 10b. County	140-	Oh. T.								
	ahou a	_		10c.		m or Location					10	0d. Insida Cit 1 ☐ Yas	
	the Marylar 28a-f ehow notified at	octo	Maryland Cecil		Risi	ng Sun							242140
	vith to	Director	10e. Street and Number			101. 2	Zip Code			10g. Citizen of	What Count	lry?	
	after death with the Maryland or fleme 23s or 28s-f show refree must be notified at	Funeral	100 Woody Brown R				219	• •		USA		1-6	
		un.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S.	13. Was Dec	pecify Cul	Hispanic Origin? (ban, Mexican, Pue	Specify Yas or No rto Rican, atc.)	- 14. Had Bla	ce - America ck, Whita, e		
20	72 hours after naturel', or its	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Giva		1□ Yes	2 CX No	Specify:		Specif	y:		
8	hour		15. Decedent's Ed	Year or Dates:	160	Dogodosťe H	ual Ooo	enation		16b. Kind of B		rite	
15	n 72	Completed	(Specify only highest grad		108.	Giva kind of I lifa. DO NOT	vork done	during most of w	orking	100. KRIQ OI D	usmass/mu	ustry	
112	withi erie.	m	Elementary/Secondary (0-12)	College (1-4or 5+)	(0)	elder	000 10111			Moxlei	, work	lina	
P	Hygi Hygi		17. Father's Nama (First, Middle, Last)		1 00	ecuei		18. Mother's Ne	ema (First, Middle,			izng	
Maryland 21215-0020	d be ental	To Be	Ernest A. Reynold	14				Mae WI	halon				
7	M bu Mari	-	19a. Informant's Name/Relationship (7		19b	. Mailing Addre	ss (Stree	et and Number or F		er, City or Town	Stata, Zip	Coda)	
Z	ith a tree		Ruth Johnson					Brown Roo					
re,	Hear term office	1	20a. Mathod of Disposition	20	o. Place o	Disposition (A	lama of		Dete	20c. Location			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiere. Important: If Item 27 Ie marked other than "naturel", any Injury or other treumatic event, the Medical Ex-		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify			ny, crematory o			7.05.00	Calara	Man	Pand	
量	artm ortan	-	21. Signature of Funeral Service Licen		100			Cemetery ass of Facility	7-23-00	Cozona,	Mary	Lana	
Ba	P G E E		111	P(1 -	10			ard Fune ueen St.	ral Home	P. A.			
	1504	-	23a. Part 1. Enter the disease, or come	Too of	math. Do	111	S. Q	ueen St.	, Rising	Sun, MI	2191	Approximate	
			shock, or heart failure. List only o	one cause on each line.	ment. DO	THOSE GENERAL ENGINE	oue or uy	arg, such as calcul	ac or raspiratory a	ilast,		Intarval Baty Onset and D	ween
	Physician /Medical		Immediata Causa (Finai	0	Λ			0	(
2	Examiner		disease or condition resulting in death)	a	to	mank	eak	lung	auc	er			
		-		Due to	o (or as a	consequence o	():						
	De it	Examiner		b							i		
-	certificate be axecuted uding physician and use es the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a	consequence o	1):						
68760,	sicial buri		Cause (Disease or injury that initiated events	C									
89	e es the	edical	resulting in death) Last	Due to	(or as a	consequence o	1):						
Вох	nding	3		d									
Ö	iras that the death ce signed by the attendi d be detached for use	by Physician/	Part II. Other significant conditions co	entelleution to double feut aut	annultin a is	n the condent in		ion in Dod I	nah Did	tobacco use co	madbuta to	the sever s	d doods 2
0	the cy the	h ys	ran ii. Ourer significant conditions of	with both but not	i Bauting ii	ir are underlying	j causa y	Wen in Parci.		Yes 2□No		pably 4 🗆 t	
0,	that the ned by th s detach	7								108 20100	3/4/100	40, 40,	DITKHOWIT
Records,	requires een sign hould be	8							24a. Was	an autopsy		ara autopsy fi	
00	w require been si should I	Completed				الصحاة			репо	rmed?	con	ailabla prior to mpletion of ca death?	
Re	The law ste has b	E							10	Van osalia		Yes 20	No
a	certificate rector, pag		25. Was casa refarred to medical					00 Dl1 D	10) 165 ZLI	140
of Vital	Physicien: The I this certificate he ral director, page	00	examiner?	Hospital:	C cno.	tantina all	0	ther	eath (Check only o		and (Consist	d	
	5 5 7	2	27. Manner of Death		28b. 1	rtpatient 3 (28c. Inju	- Indiang	Homa 5 Rasi	how injury occu		9	
on	ding th.	i i	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year		njury M		ork?]Yas 2∐No					
Division	Attending or death.	Certification:	3 Suicide 6 Could not be	200. Place of Injury - A	t home, fa	ırm, street, fact	ory, office			Street and Num	ber or Rure	l Routa Num	ber,
á	afte Dire	2	4 Homicide	building, etc. (Spe	ecity)				City or To	wn, Steta)			
	epita nours neral	<u>8</u>	29a. Certifier 12 Certifying Phy	raician: To the best of my t	cnowledge	, death occurre	d at the t	ime, date end place	e, end due to the	cause(s) end m	enner as st	ated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medicat Exam	Iner: On the basis of exam and manner stated.	inetion an	d/or investigation	on, in my	opinion, deeth occ	curred at the tima,	date end place,	and dua to	tha cause(s)	,
	Withir To th		29b. Signature and title of certifier	0		2	9c. Licer	ise number		29d. Date signe	d (Month, I	Dey, Year)	
			yoles	Kalet			710	3.15		7	W	N	
	1	-	30. Nama and addrass of person who o	ompleted cause of death ()	tem 23a)		J18 G	170		,			
	6			IW. HIGH S		EUKTON	M	2192					
	Stat	е	31. Data filed (Month, Day, Year)	32. Registrar's Signature		1 1	, ,(, -110					
	Ponistro		1111 9 5 2000	Menera	/	4 1	100						



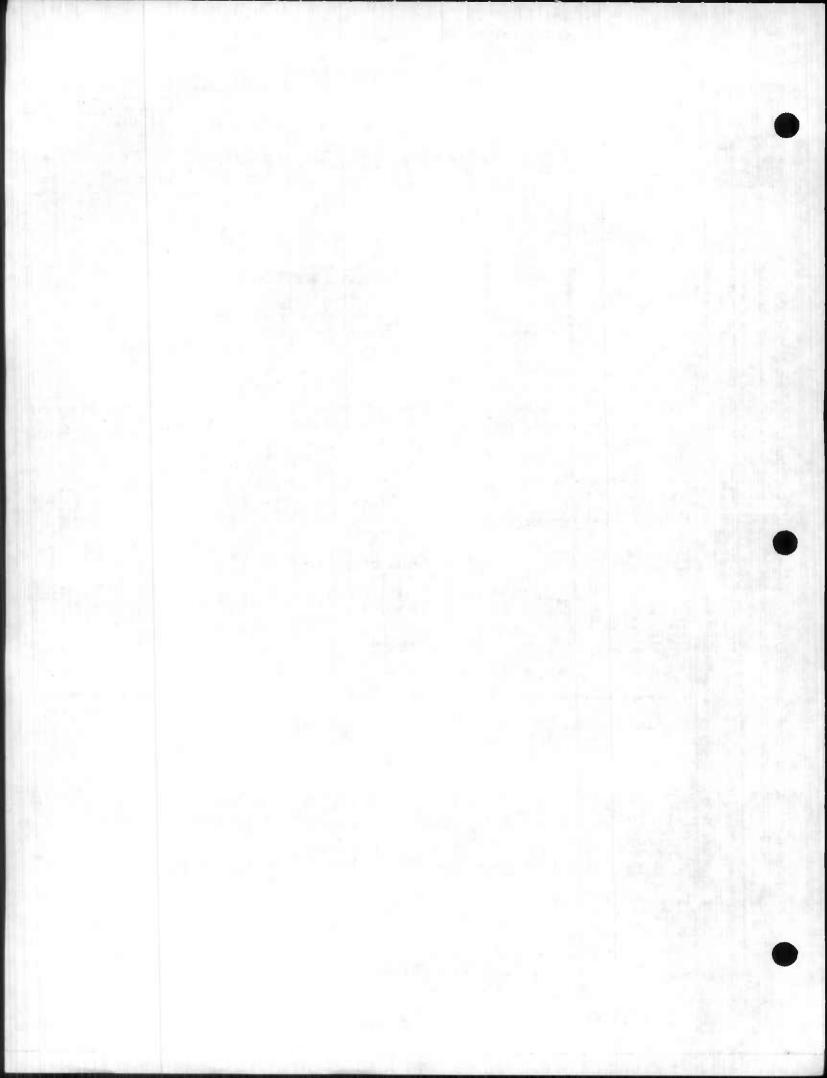
State of Maryland / Department of Health and Mental Hygiene

24634 Certificate of Death

				06	si tilicate U	Dealli	R	g. No.		
	Physician /Madical	Decedent's Name (First, Middle, L Guy D. Rhoade:					2. Data of Deat	h Day 22		Death
	/Medical Examiner	4a Facility Name (If not institution, g Union Hospita		IIV III E		4b. City, Town, or Elkton		4c. County		
	Funeral Director	216-05-3928		(In yrs. last birthda)	Months Day	s Hours Min.	(Month, Day,		9. Birthplace (Sta Country) Marylan	
	/land	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location			10.1	10d. Insid	de City Limits
	Ba-1 sh	Maryland Cecil		Elkton						Yes 2□No
	3a or 2	10a. Street and Number 213 West Main	n St.		10f. Zip Code 2192			U . S . A		
20	72 hours after death with the Maryland natural; or items 23a or 28=1 show netural; or items 25a or 28=1 show netural by the property of the pr	11. Marital Status 1 Never Married 2 Married 3 Widowed **Chivorced	If Yes, Give		i. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puerlo o Specify:	pecity Yes or No- to Rican, etc.)	Blac	e - American India ok, White, etc. o: White	n,
2-00	"natural", or detect by F	15. Decedent's I	Year or Dates:	16a. Dec	edent's Usual Occ	upation		16b. Kind of Bu	usinass/Industry	
21215-0020	Jwithin Jiena.	(Specify only highest g Elementary/Secondary (0-12) 12	College (1-4or 5+)		Owner	e during most of wo			ial Cle	aners
Maryland	tal H d out	17. Father's Nama (First, Middle, Las Charles F. Rho					me (First, Middle, M tte War		ne)	
Mar	d 2 should the and Men 7 is marke traumatic	19e. Informant's Neme/Relationship Ann M. Magaw				et and Number or Ri				
	s 1 and 1 the lith trem 27 lother tr	20a. Method of Disposition			position (Name of rematory or other p				City or Town, Stat	le
Baltimore,	permit. Pages 1 a Department of Has Important: If item any injury or othe page.	XIXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				emetery7	/27/00C	harles	stown, M	d.
Balt	permit. Departri Importa any inju	21. Signature of Funaral Service Lice	ensee		22. Name and Add	0	ee Fune			
	40244	23a. Part1. Enter the disease, or con	molications that caused th			Main St.			21921 Approx	cimate
	Physician	shock, or heart failure. List onl	y one cause on each line			¢.			Interva	Between and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a acuta r	myo can	dial n	n function	Â		m	edute
		1 loouting it doubly	D	ue to (or es e cons	equence of):					401
o,	physician and sthe burish transit sthe burish transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. <u>Corona</u>	ua to (or as a cons		secre				71-
ox 68760,	certificate be executed nding physician and use as the burial-transit n/Medical Examir	Cause (Disease or Injury that initiated events resulting in death) Last	CDı	ue to (or as a cons	equenca of):					
Ö		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying causa	givan in Part I.	23b. Did to	bacco use co	ntribute to the ca	use of death?
P.0	at the death d by the attai setsched for Physicia						1 U Y	e 2□No	3 Probably	4 Onknow
Division of Vital Records,	The law requires that the death sate has been signed by the atterpage 2 should be deteched for Completed by Physicia						24a. Wes a periori	n autopsy ned?	24b. Were euto available p completion	prior to
Rec	6 - 0 -	Team a Hill					1 🗆 Y	s 2DNo	of death?	2□ No
/ital	certificata rector, pag	25. Was case referred to medical examiner?					ath (Check only on	e)	1	
of \	F SE D	1 ☐ Yes 2 ☑ No	Hospital:		ent 3L DOA		dome 5 ☐ Reside			
slon	tal or Attending PP is after death. al Director: After the director by the funeral led in by the funeral Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	he		M 1	□ Yas 2 □ No				At making
Div	s after of Direct of in by	4 Homicide determine			street, factory, offic	9	City or Town		per or Rural Routa	wumber,
	To the Hospital or Attending Plantin 24 hours after death. To the Funeral Director: After to complately filled in by the funeral complately filled in by the funeral Medical Certification:		thysician: To the best of aminer: On the basis of a and mannar state	xamination and/or						use(s)
	To the To the Comp	29b. Signatura and title of certifier				nse number	2	,	d (Month, Day, Ye	iar)
		nuy	MD	de la constante	0.	44102		7/23	100	
	10	30. Name and address of person who WILLIAM RENZ		th (Item 23a) (Type 901 WAK		D. 22	Tow, n	2 . 2	1591	Enmi
	State Registrar	31. Date filed (Month, Day, Year) JUL 2 5 2000	Seres 32. Registrar	s Signature	local					

DHMH 16 Rev 6/95

Sporks



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month 8:45 pm John Lawrence Searles July 25, 2000 4b. City. Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year 6. Sax 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months Deys 1 M 2□ F 008-14-0032 Nov. 3, 1924 Vermont Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Charlotte Hall St. Mary's Maryland 1 ☐ Yes 2 ■ No 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 20622 United States 29449 Charlotte Hall Road 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yas 2 No 1948 If Yes, Give Yaar or Detas: 1953 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 1953 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Engineer U.S. Government 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William J. Searles Margaret Agnes 9b Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8703 Timothy Road 20012 19a. Informent's Neme/Reletionship (Type, Print) Kenneth James Miles 20613 Son 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removel from State 21. Signatur d'uneral Service Licenses May B. Rizzo 7-26-00 Charlotte Hall, MD Brinsfield-Echols 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 2001114 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only an earlier on each line. Approximate intervel Between Onset end Death Immedieta Causa (Final Pneumonia disease or condition resulting in deeth) Resistance Staphylococcal Aureus Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3(☐ Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No meumothorax. 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Demementia completion of cause of death? COPD 1 Yas 2 No 1 Yes 2 No 25. Wes case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending 1 Yes 2 No investigetion

the burial-tran Box 68760 Physician/Medical þ Completed of Vital Be Certification: To this After Division or Attending death. after deat Director: To the Hospital of within 24 hours at To the Funeral D completely filled

Physician

/Medical

Examiner

Director

Funeral

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If Item 27 is

Physician /Medical

Examine

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State Registrar

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29b. Signatura and title of certifier

6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D 50653

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

29d. Date signed (Month, Day, Year) 7-26-2000

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

GYAN-C. SURANA 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Deale church ton Road: Deale MD

31. Data filed (Month, Dey, Year)

3 ☐ Suicida

29e. Certifier

4 - Homicide

JUL 28 2000

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 24636 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 27, 2000 7:00 am Suntich Annette 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mechanicsville St. Mary's 27909 Parrish Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 F 75 197-20-8052 Yrs. Feb. 14, 1925 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Mechanicsville St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20659 27909 Parrish Court 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ■ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2College (1-4or 5+) Elementary/Secondery (0-12) At Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Mary Paniak George Popawitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 27909 Parrish Court, Mechanics Ville, MD 20659 19a. Informant's Name/Relationship (Type, Print) Son Victor Suntich 20b. Place of Disposition (Name of cametery, crematory or other place) July 31, North 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State Versailles, PA Grandview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Almerai Service Licensee 22. Name and Address of Facility B Brinsfield Funeral Home, P.A., 22955 Hollywood Rizzo M01114 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) LUNG CANCER 8 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events.) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 ☐ Unknown 1 Yee 2 No Rheumatoid ARTHRITIS 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? ANEMIA completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 🛩 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00

physician and s the bunal-transit The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, attanding pl signed by the a after death.

Director: After this cartifica To the Hospital or A within 24 hours after To the Funeral Direcompletaly filled in b

Physician

/Medical

Examiner

10a. State

Maryland

Directo

Funeral

p

Completed

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Plages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Inspectant, If Item 27 is marked other than "naturel", or items 23s with injury or other treumatic event, the Medical Examples of the process.

Physician

/Medical

Examiner

Examiner

Physician/Medical

p

Completed

Be

Certification: To

Medical

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

director,

funeral

Baltimore, Maryland 21215-0020

with the Manyland

State Registrar

2 8 2000

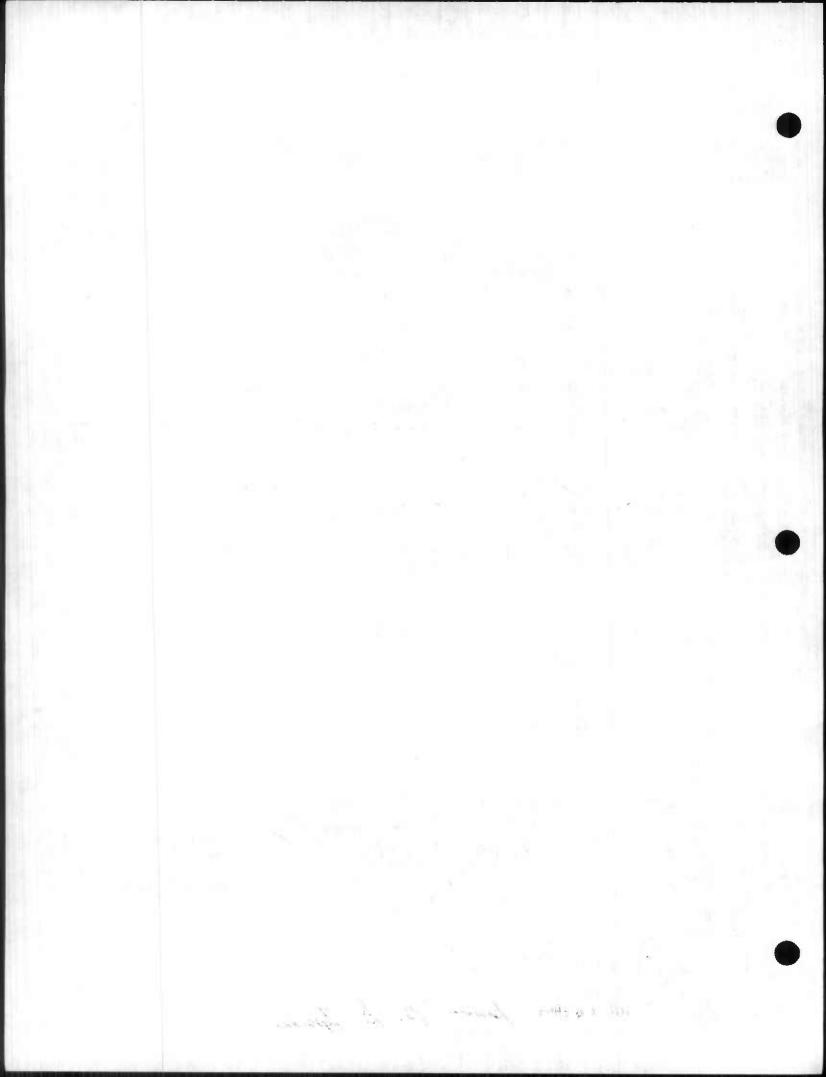


30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

- Secret 101 - Secret 101

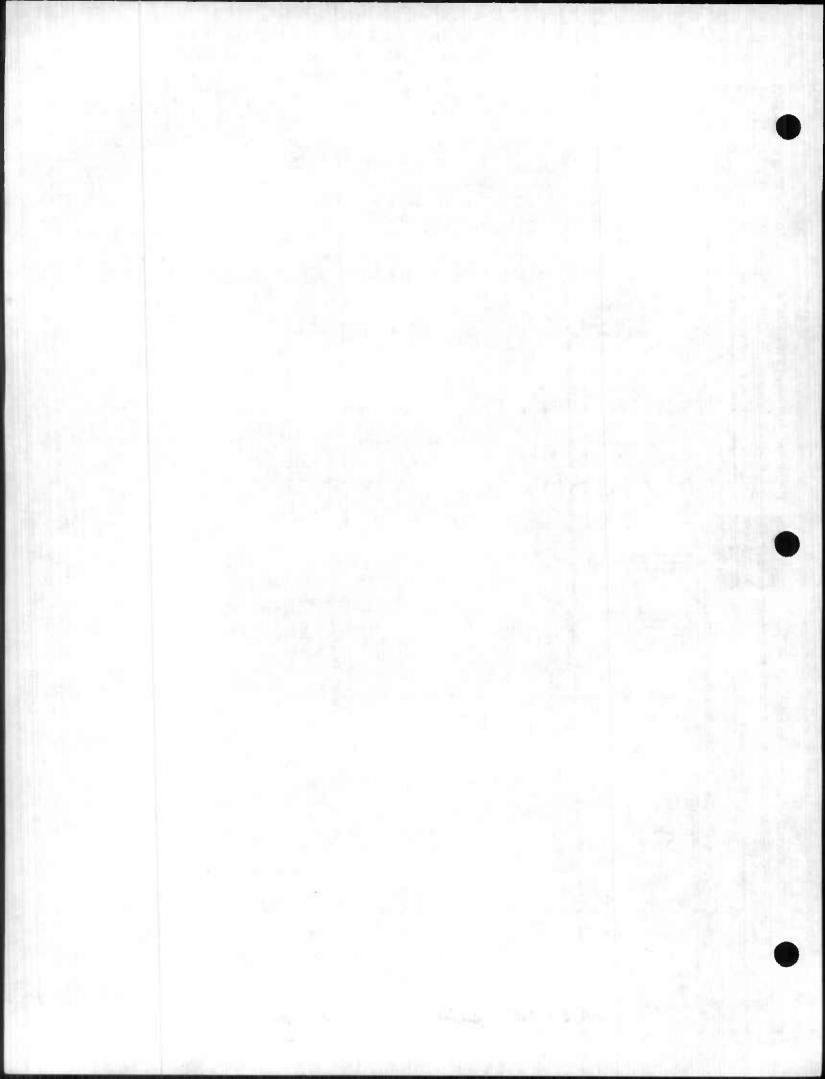
State of Maryland / Department of Health and Mental Hygiene 00 24637

		Ce	ertificate of	Death	Re	g. No.	24001
	1. Decedent's Nama (First, Middla, Last)				2. Date of Death Month	Dev Yea	3. Tima of Death
Physician /Medical	Tonya Lynn Smith				JULY	13 200	
Examiner	4e Fecility Nama (If not institution, giva street and numb	er)	VE PER	4b. City, Town, or Lo	cation of Death	4c. County of De	ath
	HAWIHORNE ROAD WEST OF VA	LLEY ROAD		INDIAN H		CHARLES	
Funeral Director	5. Social Security Number 6. Sex 7.	Aga (In yrs. last birthdey 21 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day, July 23	9. 8 , 1978 N	irthplaca (Stata or Foraign Country) Maryland
7 .	Usual Rasidanca of Dacedent	40.03.7					4011 111 011 11 11
styla data	10e. Steta 10b. County	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yas 2 ☐ No
Ne M Sa-f pulfis	Maryland St. Mary's	Mechan	icsville				
vith the Mo t or 28a-f1 be notified	10e. Street and Number		10f. Zip Coda		10	g. Citizen of What (Country?
ath man	24485 Chaptico Hurry R		2065			U.S.A.	nerican Indian,
A 1 X 1 S-UUXO d within 72 hours after death with the Maryla plens. r than "natural", or thems 23s or 28s-f sho the Medical Examiner must be notified at completed by Funeral Director	11. Merital Status 11. Never Married 2 Married 12. Was Deceded Armed Force, 1 Pas, Giva 13. Widowed 4 Divorced Yaar or Date	Ď No	. Was Decedent of P If Yes, specify Cub 1 ☐ Yas 2 ☑ No	dispanic Origin? (Spe an, Maxican, Puarto Specify:	Rican, etc.)	Black, Wi	
2 ho 2 ho	15. Decedant's Education	16a. Dec	edant's Usual Occup	pation	1	6b. Kind of Busines	ss/Industry
led within 72 ho lygions. her than "naturn it, the Medical.	(Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4)	or 5+)	DO NOT usa ratire	during most of worki	rig		
	9th		ashier			Retail S	Store
De illa Hy	17. Famars Nama (First, Middia, Last)			18. Mothar's Name			
Menta Menta	David Wayne Shotwell			Ruth A	nn Buckl	er	
Maryland 2 should be flie th and Mental Hy 7 is marked oth traumatic event	19a. Informant's Name/Ralationship (Type, Print)			and Number or Rura			
- 등들어는	Kevin Allen Smith - Spous			3, Mechan			
of the control of the	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Str	20b. Place of Disp cametery, cra	position (Nama of amatory or other pla	ca)	Data 2	Oc. Location - City	or Town, Stata
Politimore, permit. Pages 1 a Papariment of Health mportant: if item my injury or other most.	4 Donation 5 Othar (Specify)	Charles	Memorial	Gardens 7	/19/2000	Leonardt	own, Marylan
Physician /Medical	23a. Part 1. Entar tha disaasa, or complications that cau shock, or heart failura. List only ona causa on act	en P	.O. Box 2	r-Gardiner 270, Leona ng, such as cardiac	rdtown,	Maryland	
Examiner	disease or condition rasulting In death) a.	Dua to (or as a const	equanca of):		ZI (C	3	
death certificate be executed eatherding physician and dor use as the bunk-transit stellan/Medical Examine	Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last	Due to (or as a conse					
box attendin for use	d						
A by the detache	Part If. Other significant conditions contributing to deat	h but not resulting in the	undarlying causa gi	ven in Part I.	23b. Did to		re to the causa of death? Probably 4 Unknown
been s should					24a. Was ar		b. Wara autopsy tindings available prior to complation of cause of death
The lay ate has page 2					1 Ya	s 2 No	1 √as 2 No
certificat rector, p	25. Was casa rafarred to madical			26. Placa of Deat	-		
Physician: this certific ral director,	examinar? 1	atient 2 ER/Outpati	ent 3 DOA Ot			nca 6 Nothar (S	pecify) SCENE
or Attending or Attending ther death. Mector: After in by the fune fune triffication	27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigation 3 Suicide 6 Could not be	1	30 M 28c. Inju	ry at ink?] Yas 2 No	Drive Collid	w injury occurred	Leter Vehicle h Truck Aural Routa Number, horne Rol.
n 24 houpin 24 houpin 24 houpin 54 houpin 55 h	29a. Cartifiar (Check only one) 1 Certifying Physician: To tha be 2 Medical Examiner: On the basi and manna	s of axamination and/or i	invastigation, in my	opinion, daath occurr	ed at tha tima, da	ita and placa, and c	lua to tha causa(s)
To the Common	29b. Signatura end title of certifiar	ALL	29c. Lican	se number	29	d. Data signad (Mo	onth, Dey, Year)
	Hestanin	MI.D.	0.	C.M.E.		JULY 14.	2000
	- COO CO CO CO CO CO CO CO CO CO CO CO CO	er 1	e, Print)	treet, Ba	ltimore,		
State Registrar	31. Date (Month Pay, Year) 2000 32. Res	istrar's Signature	. B. J	Joe For			



State of Maryland / Department of Health and Mental Hygiene 00 24,538

			Cer	titica	te of	Death		Reg. No.		
	1. Decedent's Nema (First, Middle, La	ist)					2. Data of D Month	Death Dey	Yeer	3. Tima of De
Physician /Medical	EUGENE THOM	IAS STONE,	JR.				JULY	17 2	2000	9:00a
Examiner	4a Fscility Nama (If not institution, giv	re street and number)				4b. City, Town,	or Location of Dea	ath 4c. Cour	nty of Deeth	
	22900 WHITE	S FERRY R	OAD			DICKER			ITGOM	
eral ctor	213-40-4004	6ex 7. Age (10 5 5	In yrs. last birthday) 2 Yrs.	If Unde Months	Days		in. 8. Date of E Month, I SEPT	Birth Day, Year) 15 194	9. Birth Cou	placa (State or Fo intry) MD
	Usuel Residence of Decedani 10a. Stete 10b. County	1	Oc. City, Town or Lo	cation						10d. Inside City L
Director	MD MONTGO		DICKERS							t ☐ Yes 2
al Directo	10e. Street and Number 22900 WHITE	S FERRY R	OAD		208	42		10g. Citizen o	of Whet Cou	untry?
by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Even Armed Forces? 1 Yes 2 No If Yes, Giva Yeer or Detes:	if	Vas Dece f Yes, ape	ecify Cub	an, Maxican, Pu	(Specify Yas or Narto Rican, etc.)		leck, White	icen Indien, , etc.
Completed	15. Decedent's Ed (Specify only highast gra		16e. Deced	lent's Usu kind of w	al Occup	pation during most of	vorking	16b. Kind of	Business/Ir	ndustry
nple	Elementary/Secondary (0-12)	Collega (1-4or 5+)			use retire	during most of (3.7750.0		
S	12		SAI	LES		T. A. A	1 4000 - 5.00 4.4	AUTON		E
B B	17. Father's Neme (First, Middle, Last,						Neme (First, Midd			
2	EUGENE THOMAS						THY DON			
To Be C	19a. tnforment's Name/Raletionship (Rural Route Num			
other	CHARLES STONE/		#5 I			CT., G	AITHERS	7		20882
8	20e. Mathod of Disposition 1 Disposition 3		cemetery, crem	netory or	othar ple	ice)	Data	20c. Locatio	n - City or I	own, Steta
	4 ☐ Donation 5 ☐ Other (Specif	(y)	ENDERS/S	SHIR	LEY	F.H.	7/18	BERRY	VILL	E, VA
eny injury once.	21. Signature of Funeral S	nsee W	HI	LTO	NF	ess of Fecility UNERAL BARNES	HOME VILLE,	MD 20	0838	
10	23e. Part1. Enter tha disease, or com shock, or heart failura. List only	plications that ceused the								Approximata Interval Between
ian										Onset end Dea
lical iner	Immediate Ceuse (Final disease or condition resulting In daeth)	HEPATI	C ENCEP	HAL	PAT	YHY			: 1	MONTHS
5	resulting in decitiy	Du	a to (or es a conseq	uence of)):					
		b. HEPATI	TIS C						1	YEARS
al Examin	Sequentially list conditions,		a to (or as a conseq):				-	
	Sequantially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury	ALCOHO	DL ABUSE						-	YEARS
odic	thet initiated events rasulting in death) Last		e to (or es e consequ	uence of)				300		
Physician/M	Pert II. Other algorificant conditions of	ontributing to death but r	not resulting in the ur	nderlying	ceuse gi	ven in Pert I.	23b. Di	id tobacco uss	contribute	to the cause of d
detached y Physi				, ,			1(□ Y88 2 2 N	3 ☐ Pr	obably 4□Un
page 2 should be d								es en eutopsy rformed?	a	Vare autopsy find iveileble prior to completion of caus of deeth?
Com							1[Yas 25 No	1	☐Yes 2☐No
rector. pag	25. Was cese referred to medical					26. Place of I	Deeth (Check on)	y one)	1	
To Be	examinar?	Hospital: 1 Inpatient	2 ER/Outpatien	t 3□ D	OA OI	her: 4 Nursin	Homa 5 Re	sidance 6 🗆 0	Other (Spec	cify)
	27. Mannar of Death 1 Naturel 5 Pending	28e. Dete of Injury (Month, Day Y	(ear) 28b. Time of Injury	М	28c. Inju Wo	ry at ork?] Yas 2 ☐ No	28d. Describ	e how injury occ	curred	
Certification:	2 Accident investigetion 3 Suicide 6 Could not b 4 Homicide determined	e One Olege of this and	- At homa, farm, stre Specify)			, 143 2 140		(Street end Nu Town, Stata)	m <i>ber</i> or Ru	ral Routa Number
Medical Cert		nysician: To the best of n niner: On the basis of ax end mennar state	amination end/or inv							
<u> </u>				29	c. Lican	sa number		29d. Date sig	nad (Month	n, Dey, Year)
X X	29b. Signature and title of certifier							1		
Me	29b. Signature and title of certifier			Т	0417	731		JULY	18.	2000



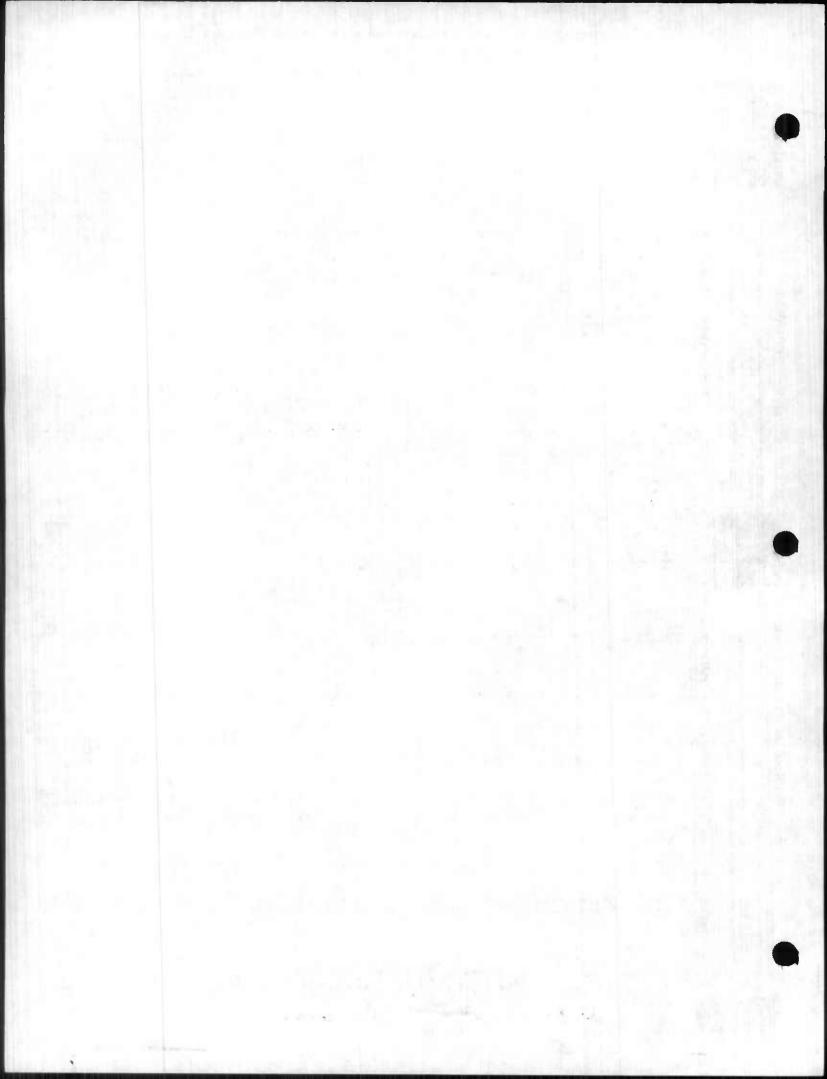
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22 George L. Snyder July 2000 6:30 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 11 M 2 F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Yrs. 236-16-6750 89 May 29, West Virginia **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State I hydene. other than "natural", or frame 23e or 28a-f show went, the Modine Exemples must be notified at 1X Yes 2 No Directo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 Russell Avenue 20877 U.S.A. Funeral filed within 72 hours after deeth 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2K No Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Soil Conservationist U.S. Government permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked other any injury or other traumatic event bace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be R. Thomas Snyder Bernadine Dixon Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Snyder - Daughter 14303 Rectory Lane, Upper Marlboro, Maryland 20772 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 7/26/00 Lewis County, West Va. 4 ☐ Donation 5 ☐ Other (Specify) Mitchell Cemetery Olin L. Molesworth P.A., Funeral Home 21. Signature of Funeral Service Licensee Muans overt 26401 Ridge Road, Damascus, Maryland 20872-0117 riter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to (or as a consequenca ot) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ettending physicien the Due to (or as a consequence of): 188 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner?\ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Affer 5 Pending investigation Natural 1 Yes 2 No after death. **2** ☐ Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and menner es steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29a Certifier 29b. Signature/and title of certifier 29c. License number 29d_Date signed (Month, Day, Year) 11205/6 and address of person who completed cause of death (Item 23a) (Type, Print) GeorgeTown 94/0 2000 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 24 54 0

				Ce	ertificate (of Death		Reg. No.		
Dhan't t		1. Decedent's Name (First, Middle, Le.	st)	VO 10			2. Date of De Month	eath		Time of Deeth
Physicia /Medic		HENRIETTA SE	LLMAN				JULY	17 200	O 1	0:35 am
Examin		4e. Fecility Name (If not Institution, give	e street end number)			4b. City, Town, o	r Location of Deel	th 4c. County		
		926 W. BENNING	G ROAD			GALESVI	LLE	ANNE	ARUNDE	L
Funeral		Social Security Number 6. S	THE SPINE		/) If Under 1 Y Months Da	eer If Under 24 Hr lys Hours Mir		rth ey, Year)	9. Birthplece	(Stete or Foreign
Director		213-05-0024 Usuel Residence of Decadent	84	Yrs.			APRIL		5 MARY	LAND
how		10e. Stete 10b. County	10c. Ci	ty, Town or I	Location					nside City Limits
72 hours after death with the Maryland natural, or thems 23a or 28a-f show ocal Examiner must be mutited at	Director	MARYLAND ANNE I	ARUNDEL GA	LESV	ILLE 10f. Zip Coo	4-		40a Ohinan -41		X Yes 2□No
with or		Toe. Street end (Vanibe)			TOI. ZIP COO	10		10g. Citizen of \	whet Country?	
eatri	era	926 W. BENNING	ROAD 12. Wes Decedent Ever In L	IS 13	Was Decedent	765 of Hispenic Origin? (Cuben, Mexicen, Pue	(Specify Ves or N	US	A - American Ir	ndien
ours after death was all, or Herrs 23s	/ Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		If Yes, specify (rto Rican, etc.)	Specify	ok, vvnite, etc.	
n 72 hours natural',	d by	3 XWidowed 4 □ Divorcad	Yeer or Dates:	100						
n 72	Completed	15. Decedent's Ed (Specify only highest gre	de completed)	(Giv	edent's Usuel Od te kind of work do DO NOT use re	ne during most of w	orking	16b. Kind of B	usiness/Industr	У
y within jene. r than	Dub	Elementery/Secondery (0-12) 6th	College (1-4or 5+)		ESTIC	inouj		OUT OF	THE H	OME
프로 현 등	Be C	17. Fether's Neme (First, Middle, Last)	0	DOM	DOTIC	18. Mother's N	eme (First, Middle			OME
	To B	JAMES CROWNER				MAMIE	GROSS			
th and Mer 7 Is marke traumatic		19e. Informent's Name/Relationship (Type, Print)	19b. Mei	ling Address (St	reet end Number or F		er, City or Town,	Stete, Zip Coo	(e)
		DORIS FOOTE (DA	AUGHTER)	926	W. BEN	INING RO	AD GALE	SVILLE	, MD.	20765
- I E S		20a. Method of Disposition			position (Neme o		Date	20c. Location -	City or Town,	Stete
ant and		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovel from State			CH CEME.	7/21/0	O GALES	SVILLE	, MD.
pamit. Pa Dapartman Important: any Injury once.		21. Signeture of Funeral Service Licen	see NO048"	3 :	22. Name end Ad	Idress of Fecility				
Dap Imp		Larry D. Ro		1	WM. REI	ESE & SOI	NS MORT	UARY, 1	P.A.	
		23a. Pert1. Enter the disease, or compshock, or heert failure. List only	plicetions that caused the dee	h. Do not e	S21 WES	dying, such es cardi	NNAPOLI ac or respiretory e	S, MD.	21401 APR	roximete
hysician		anock, or need tailers. List only	one cause on eech line.	A	- 1				One	rval Between set end Deeth
/Medical		Immediete Ceuse (Finel disease or condition	Unimi	A	edo	SIN			0	ins
Examiner		resulting in deeth)	Due to (or es e conse	equence of):	000		- PI		
2 %	Examiner		Renal	Fa	Jure				1	year
g physician and as the burial-transit	xam	Sequentially list conditions,	U	or es e conse	equence of):				2	
cian		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury	C							
nding physicia use as the bur	edicai	thet Initieted events resulting In deelh) Lest	Due to (d	r es e conse	equence of):					
.S @	2		d							
for L	Physician/									
0 2	ysi		maniferation of a manual burner of a manual							
20		Pert II. Other eignificent conditions co	ontributing to deeth but not res	ulting In the	underlying ceuse	given in Pert I.		tobacco uee co		
ned by the e detached		Pert II. Other eignificent conditions or	ntributing to deeth but not res	ulting In the	underlying ceuse	given in Pert I.		tobacco uee con Yes 2 No		cause of death?
b ed	P	Pert II. Other eignificent conditions of	niributing to deeth but not res	ulting In the	underlying ceuse	given in Pert I.	1 - 24a. Wes	Yes 2 No	3 ☐ Probably	4 Unknown
pe d	P	Pert II. Other eignificent conditions of	miributing to deeth but not res	ulting In the	underlying ceuse	given in Pert I.	1 - 24a. Wes	Yes 2 No	3 Probably 24b. Were e eveileble comple	4 Unknown utopsy findings e prior to
s been signer	P	Pert III. Other eignificent conditions of	ntributing to deeth but not res	ulting In the	underlying ceuse	given in Pert I.	1 □ 24a. Wes	Yes 2 No	24b. Were e eveileb comple of deeth	4 Unknown utopsy findings e prior to tion of cause
ata has been signed paga 2 should be d	Completed by	25. Was case referred to medical	ntributing to deeth but not res	ulting In the	underlying ceuse		24a. Wes	Yes 2 No	24b. Were e eveileb comple of deeth	4 Unknown utopsy findings e prior to
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ringstorant. The law requires in this certificate has been signed and director, page 2 should be d	To Be Completed by	25. Was case referred to medical exeminer? 1 □ Yes 25 No 27. Menger of Deeth	Hospitel: 1 ☐ Inpatient 2 ☐ 28a. Dete of Injury	ER/Outpetie 28b. Time	ent 3□ DOA	26. Piece of Do Other: 4 ☐ Nursing	24a. Wes perfe	Yes 2 No sen eutopsy rmed? Yes 2 No one)	3 Probably 24b. Were e eveilebi comple of deett 1 Ye.	4 Unknown utopsy findings e prior to tion of cause
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		1. Decedent's Nama (First, Middle, Las	it)					2. Dafa of D	eath Day	Yaar 3.	. Time of Death					
	Physician /Medical	Helen Medora	Smi1	.ey				July			2:30 a.m.					
	Examiner	Ab City Town of Lo														
		3742 Smiley Lane							Anne A	Arundel	L					
	Funeral Director			7. Aga (In yrs. 193	last birthday) . Yrs.	Months Days		lin. (Month, D	irth lay, Year) 14, 1907	Country)	Chusetts					
	2 .	Usual Residence of Decedent	2. Date of Medora Smiley Smiley Ab. City, Town, or Location of Explayment Ab. City, Town, or Location Comment Comment Ab. City, Town or Location Comment Com													
	anyte des	10a. State 10b. County		10c. City	y, Town or Loc	cation					Inside City Limits 1 ☐ Yes 200000					
	or 28a-f			Pile	sgrove											
	with the Mary s or 28a-f sh he notified. Director	10e. Street and Number				1000			10g. Citizen of V							
	e 23	208 Marlton Rd.	40 Mee Dee	adout Francis III	C 12 V		Hispania Osinin'i	(Cascily Vac or N	United	S Calles a · American I						
0	her death r hems 23 siner must Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	orces?	if if	Yas, specify Cub	oan, Mexican, Pu	uarto Rican, etc.)	Blac	k, White, atc.						
Maryland 21215-0020	uraf, or h al Examin od by Fu	3 ₩ Widowed 4 Divorced	If Yes, Gh	ve	1	☐ Yes 2 No	Specify:			. White						
5-	ed within 72 ho yglene. wr than "natur r, the Medical. Completed	15. Decedent's Ed (Specify only highast gra	ucation da completed)		16a. Deced (Give)	ent's Usual Occu kind of work done	pation during most of	working	16b. Kind of Bu	usiness/Industr	ry					
121	m Pan	Elementery/Secondary (0-12)		1-4or 5+)			(a)	O II.								
7		12 17. Father's Name (First, Middle, Last)								Own Home						
an	B e e of the	Archie Dean					1987		o, maioon coman	,,,						
ary.	To To	19a. Informant's Neme/Reletionship (Type, Print)		19b. Mailin	g Address (Street			ber, City or Town,	State, Zip Coo	de)					
M	177 a 177 a			son)												
re,	F Head from the colline	20a. Method of Disposition	, 51.	20b. P	lace of Dispos	sition (Name of			20c. Location -	City or Town,	Stete					
Pages Nent of	With M	1 ☐ Burial 2 ② Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		State				7-25-00	Brentwoo	d MD						
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ä	99188	1. TResent									ike of					
		23a. Part1. Enter the disease, or comp	plications that c	aused the deaft	n. Do not ente	ar tha mode of dyi	ing, such as care	diac or respiratory	arrest,	Api	proximete					
F	hysician	Shock, of heart fellore. List only														
	/Medical	Immediate Cause (Finel disease or condition a CANCER OF PANCREAS 3 Mo.														
200	Examiner	resulting in death)	a.													
	n and ial-transit		b													
ó		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (o	r as a consequ	uenca or):				Approximete Interval Between Onset and Death						
8760,	icate be ex physician as the burial edical Ex	Cause (Disease or injury that initiated events resulting in death) Last	C	Dua to (or	as a consequ	uenca of):	1									
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Вох	ath c									Ì						
0	the de ached ached	Part II. Other significant conditions or	ontributing to de	eafh but not resu	ulting in the un	derlying cause gi	iven in Pert I.				e cause of death?					
0	y P							10	Yes 25 No	3 Probabl	ly 4□Unknown					
rds,	neguires neen sign hould be								s an autopsy	24b. Were	autopsy findings					
00	law requir as been s 2 should npieted							_ pen	formed?		ble prior to lation of causa lth?					
Vital Record	0 - 0 -	The second second						10	Yes 2 No	1 🗆 Ye	es 2 No					
itai	certificate rector, pag	25. Was case referred to medical					26. Place of	Death (Check only	//							
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	ding Phys h. After this funeral di	27. Menner of Death 1 Netural 5 □ Pending	28a. Date	of Injury th, Day Year)		28c. Inju	iry at		28d. Describe how injury occurred Residence							
Sion	Attending in death. actor: After by the fune lification	2 Accident investigation														
			28e. Piece of Injury - At nome, farm, street, fectory, office						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
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	within To the comple	29b. Signatura and titla of certifier	0.1	, ,		29c. Licen	se number		29d. Date signe	d (Month, Day	r, Year)					
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	- 1	30. Nama and address of person who d			23a) (Type, I	Print) 6/	31 5	HADY S	ine K.	0						
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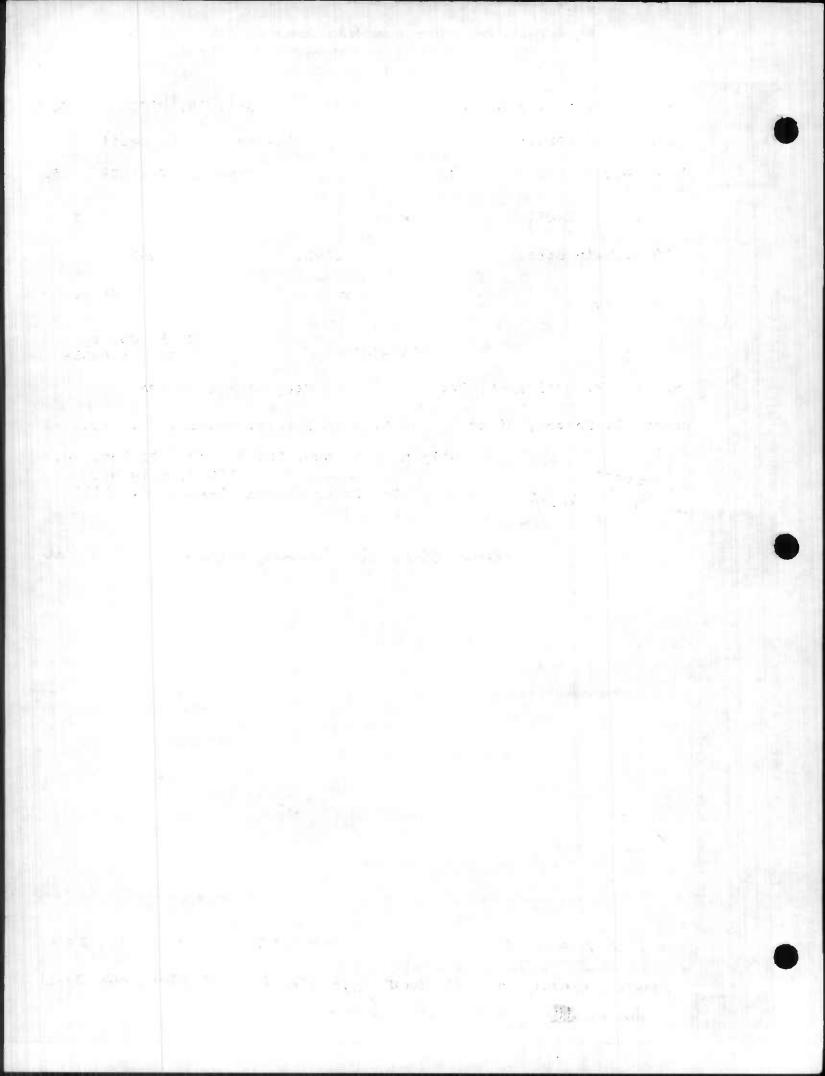
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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/Medical Examiner Funeral									4b. City, Tov	wn, or Lo						
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alyte a how	_	Md.			100.											
Ma J-4	9	Md. Cecil Elkton											X	es 2 No		
1 th	F	10e. Street and Number 10f. Zip Co.										10g. Citizen	of Whet Co	untry?		
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21215-0020 within 72 hours efter death with the Maryland iene. rthan "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status		cedent Ever in	U,S. 13.	Was Dec	edent of	Hispanic Orig	gin? (Spe	ecity Yas or N	0- 14.					
ter of the fire	- E		ied 2□ Married				If Yes, sp	ecify Cu	ban, Mexican	, Puerto	Rican, etc.)		Black, White			
300	by I			If Yes, C	Dates:	1 ☐ Yes ŽÕN						Sp	ecity: W	hite		
Hou hou	D												industry			
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be filed intel Hyg d other	Be								18. Mother's Name (e (First, Middle	e, Maiden Su	mama)			
/la	0	Huggins R. Schirling, Sr. Mar									Alverta Gonce					
Maryland 212: d 2 should be filed within th end Mentel Hygiene. 7 is marked other than traumatic event, that		19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mall	ing Addres	ss (Stree	et and Numbe	er or Run	al Route Num	ber, City or To	own, Stete, 2	Zip Code)		
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Jing Ph After th funeral	ü	27. Manner of Deal		28a. Date (Mo	e of Injury onth, Dey Year	28b. Tima Injury	of	28c. Inj	ury at ork?		28d. Describe	e how injury o	ccurred			
io india	atic	2 Accident					М		☐ Yes 2☐	Town, or Location of Death Elkton Cec Blate S. Data of Birth (Month, Day, Year) February 24, 19 10g. Citizen of Whet Ger Specify: Corigin? (Specify Yas or No- kican, Puerto Rican, etc.) In the specify: Th						
VIS Arte	F	3 Sulcida		286. Plac	ce of Injury - A	t home, farm, s	traet, facto	ry, office	е				lumber or R	ural Route N	lum <i>ber</i> ,	
Division of a transfer death. Director: After din by the fune	Certification:	4 Homicide		buil	Iding, etc. (Spe	ecity)					City or 1	OWII, SIBIB)				
pita ours eral		29a. Certifier	12 Cartifying I	hvelclen: To th	ne heet of my k	(nowledge dea	th occurre	d at the	time date an	d place	and due to the	e cause(s) an	d menner a	s stated		
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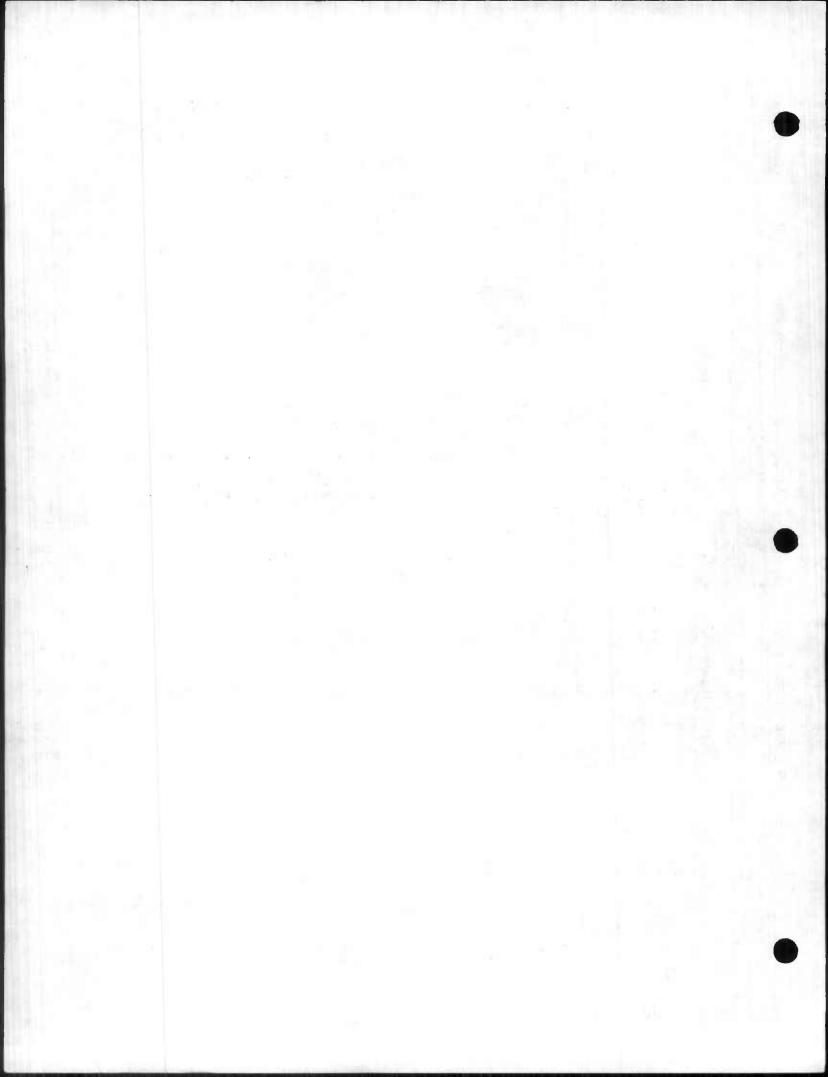
					Ce	rtificate	of l	Death			Reg. No	o.		0 . 0	
Dhysician	1. Decedent's Name	Decedent's Name (First, Middle, Last)								2. Date of Do Month			Year	3. Time of Death	
Physician /Medical	SAMUEL FREDERICK SESSA									July	01 '0000			5:45pm	
Examine	4a Facility Name (If not institution, give street end number) 116 South Main St.							Galer	na			County o			
Funeral Director	5. Social Security Nu 155-22-		Sex 1 XM 2□ F	7. Age (In yrs. la 70	st birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under Hours	24 Hrs. Min.	8. Date of B	irth Pey Year	929P	9. Birthp Cour enn	olace (State or Forei otry) Sylvani	
2 .	Usual Residence of I			100 000	Tour or Le	ontion							1.	Od. Inside City Limi	
the Marylar 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location Galena									1 X Yes 2 □ N					
t with the Ma 3a or 28a-f s at be notified	10e. Street and Num 116 Sou	10e. Street and Number 116 South Main St. 21							635 10					ntry?	
120 rs share death r, or learns 2 xaminer ma	11. Marital Status 1 Never Marrie 3 Widowed		Armed F	2 No ve 52-	If Yes, specify C		t of Hispanic Origin? (Specify Ye Cuban, Mexican, Puerto Rican, e No Specify:			ecify Yes or N Rican, etc.)	c.) Black, Wh		, White,	merican Indian, hite, etc. White	
21215-0020 ed within 72 hours at yoinne. yoinne. t, the Medical Exam Completed by		15. Decedent's Educ (Specify only highest grade			ucation 16a. Decedent's Usua (Give kind of world life. Do NOT us			Occupation k done during most of working e retired)			16b. Kind of Business			dustry	
21.2 2 with 2 with 2 with 2 with 2 with 2 with 2 with 3 wi	Etementary/Secon	dery (0-12)	College (College (1-4or 5+) Owner - (Operator				Vegetable Pa			Packing	
	17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Mic Filomena Go							
Maryland nd 2 should be liss list and Merical Hy gr is marked other traumatic event	19a. Informent's Name/Relationship (Type, Print) Phyllis Sessa (wife) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Phyllis Sessa (wife) P.O. Box 4 Galena, MD. 21635										Stete, Zip Code)				
aftimore, mit. Pages 1 a partment of Hea portant: if them: r Injury or othe	20a. Method of Dispo	sition Cremation 3	☐Removal from	20b. Place	metery, cre	esition (Neme of matory or other	r pled		7	Date /25/0				ity or Town, State	
Battir permit. P Departme importan any injur ance.	Galena Cemetery 7/25/00 Galena, 21. Signature of Funeral Company Galena Funeral Home of Stephen 118 West Cross St. Galena, MD.											en s			
Physician /Medical Examiner	23a Part. Ent. th shock, or learn Immediate Cause (F disease or condition resulting in death)	inal									arrest,			Approximete Interval Between Onset end Deeth	
OX 58760, n certificate be executed anding physician end use es the burat-transit	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): TO LIVEN and Retno- Pepartone un														
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COLDS, requires th been signe should be d		24a. Was an autopsy performed?							8/	ere autopsy finding allable prior to empletion of cause death?					
The lev ate hes page 2										10	Yes 2	E No	1	☐Yes 2☐No	
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Division of To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier (Check only		aminer: On the b	best of my know easis of examinati											
To the Comp		e continue	ealed (hr W	٨.	29c. Li	icens	e number	9			ate signed		Day, Year)	
25	30. Name and dore	. Arra	bal Jr	948	Was	Print)			. Cl	heste					
State Registrar	31. Date filed (Month	24 20		Registrar's Signat	B.	Sport	S	/							

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State of Maryland / Department of Health and Mental Hygiene

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				Certifica	ate of	Death		Reg. No.	O CHOGE				
Physician	1. Decedent's Name (First, Middle, La.						2. Date of D	eath Dey	3. Time of Deer				
/Medical Examiner	Ralph C. Scotne 4a Facility Name (If not institution, give	e street and number)				b. City, Town, or	-	23, 200 th 4c. County	of Death				
	Sunbridge Care					1kton		Cecil					
Funeral Director	101-03-2007	ex 7. Ag XDM 2□F 9	e (In yrs. last bi	Yrs. If Und Month	ler 1 Year S Days	Hours Min.		ay, Year)	Birthplace (State or For Country) Pennsylvan				
pue *	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Lir				
the Maryler 28s-1 show notified at			1 ☐ Yes 2 🔯										
5 0 0	Maryland Cecil 10e. Street and Number 147 Cliffview	Dr.			10g. Citizen of V								
urs after Mr, or he Everyn by Fur	11. Marital Status 1 Never Merried 2 Married 3 Nover Merried 4 Divorced	12. Was Decedent Armed Forces? 1 Yes XXI If Yes, Give Year or Detes:				ispanic Origin? (S n, Mexican, Puer Specify: W			e - American Indian, ck, White, etc. y: White				
ed within 72 hours ygiene. Ner then "netural; rt, tre Hearrel Eni Completed by	15. Decedent's Ed		16a	Decedent's Us	suel Occup	ation	rkina	16b. Kind of B	usiness/Industry				
d within jiene.	Elementary/Secondary (0-12)	College (1-4or 5	i+) D.4			furing most of wo	, and	Cnan (On Tools In				
Com	12	Finance Manager							Snap-On Tools In				
Be set H	17. Father's Name (First, Middle, Last)					e, Maiden Surnan	ne)						
Men Men Men Men Men Men Men Men Men Men	Ralph C. Scotn					Unknown							
	19a. Informant's Neme/Relationship (1) Ralph C. Scotn			State, Zip Code)									
dealt dealt	20a. Method of Disposition	ey 111.3	1 -1			w Dr.	North		21901				
permit. Pages 1 and 2 Department of Health a important: If Itam 27 is any injury or other tra phics.	1 Burial 2 XCremation 3 4 Donation 5 Other (Specify		cemete	pe of Disposition (Name of Pate 20c. Location - City or Town, State Ferris Inc. 7/26/00 W. Chester, Pa									
Depart Import any in	21. Signature of Funeral Service Licen	Gee Funeral Home t. Elkton, Md. 21921											
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)		CObs			Relinione	ry Dis	ause	Onset and Death				
cate be axecuted physician and s the burlal-transit adical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or es a consequence of):											
\$ 9° ~	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or es a consequence of):										
for us													
d by the letache	Pert II. Other significant conditions of Commany			g cause giv	en in Pert I.		ld tobacco use contribute to the cause of						
The law requires the sate has been signed page 2 abould be d			24a. Wes an eutopsy performed? 24b. Were eutopsy evailable prompletion										
icien: The law certificate has rector, page 2 Be Comp								~	of deeth?				
	05 W							Yes 21 No	1 ☐ Yes 2 ☐ No				
Physicien: The lights certificate he rai director, page	25. Wes case referred to medical examiner?	Hospital: Other						eath (Check only one)					
2 00	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		utpatient 3□ Time of	DOA	412 Nursing t	_	how injury occur					
To the hoppia to Attanding Physician developia to the forest deeth. To the Funeral Director: After this completely filled in by the funeral of Medical Certification: To Medical Certification: To	1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Year)	Injury M		(? Yes 2 □ No	28f. Location	it. Location (Street end Number or Rural Route Number, City or Town, Stete)						
Within 24 hours after to the Funeral Director Completely filled in Medical Cert	29a. Certifier 1☑ Certifying Phy	building, etc	of my knowledge	e, deeth occurre	d et the tin	ne, date and place	e, end due to the	cause(s) end m	enner es stated.				
in 24 hours he Funer pletshy fill	(Check only 2 Medical Exam	iner: On the basis of and manner ste	examinetion en	d/or investigation	on, in my o	oinion, deeth occi	urred at the time	, date end plece,	and due to the cause(s)				
Within Comp	29b. Signeture and title of certifier	May page		2	9c. Licens	number		d (Month, Day, Year)					
	Ha	cholers	MD		D2:	3322		7.24	1,2000				
2	30. Name and address of person who o		eath (Item 23a)	(Type, Print)									
7	S. SACHINEV	·A A	18 North		Suito	3B, E	ek En M.	021921					
State	31. Date filed (Month, Day, Year)		n's Signature	1									



State of Maryland / Department of Health and Mental Hygiene

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	00	-	Buch	U	24	V

Physician /Medical Examiner	T I						imout	001	Death			Reg. No.		
/Medical Examiner		1. Decedent's Name (First, Middle									2. Date of De Month	eth Dev	Year	3. Time of Death
	_	Ruby E. Sch	wandtne	r							July	18,	2000	2:20 PM
	- 1	la Facility Name (If not institution							4b. City, Tov	wn, or Lo	cation of Deat	h 4c. Coun	ty of Death	
		4003 Schroede					William	4.16	Perry		ee	Bo	utimo	
Funeral	5	5. Social Security Number 211-03-3953	6. Sex 1 ☐ M 2 🛣		8 (In yrs. last	Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bid (Month, Da	9,1918	9. Birth	place (Stete or Foreigi ntry) ISYLVANIA
Director	1	Usual Residence of Decedent						-			MOCCIET	7,1710	1 CILI	sycounce
ahow	1	10a. State 10b. County	36,00		10c. City, To	own or Loc	cation							10d. Inside City Limits
with the Maryland a or 28a-f show be notified at	5 /	Maryland Balt	imore				Per	Ly Ho	all					1 ☐ Yes 2 🔀 No
with the Ma or 28a-f a be notified	1	10e. Street and Number					10f. Zip	Code		1	lan to	10g. Citizen of	What Cou	ntry?
5 8 5	100	4003 Schroede	r Avenu	e				2112	28			u.s	.A.	
or items 23.	Tue	11. Marital Status	12. Was Arme	Decedent Ed Forces?	Ever in U,S.	13. V	Vas Deced Yes, spec	dent of F cify Cubi	lispanic Orig an, Mexican	in? (Spe Puerto	ecify Yes or No Rican, etc.)		ce - Ameri eck, White,	can Indian, etc.
0 0 5		1 ☐ Never Married 2 ☐ Man 3 ☑ Widowed 4 ☐ Divorced		, Give	lo	1	☐ Yes	2 X No	Specify:			Spec	ity: W	hite.
n 72 hours "natural", of call English	D -		t's Education	or Dates:	1 10	Sa Deced	ent's Heur	al Occur	etion			16b. Kind of I	Rusiness/Ir	dustry
-	Completed	(Specify only highe	st grede comple			(Give I	kind of wo	rk done	etion during most d)	of worki	ing	TOD. KING OF	Jusii 1633/11	iddatiy
iene.	E O	9th Grade	Colle	ge (1-4or 5	+)	Pharm						Drug	Ston	ie
be filed tal Hygid d other event, the		17. Father's Name (First, Middle,	Last)	111	11-14-			May 1	18. Mothe	r's Name	(First, Middle	, Maiden Sume	me)	
should be filed and Mental Hygi marked other imatic event, To Be Co	0	William Abel							Edna		Schroye	r		
s 1 and 2 should be filed within the Health and Mental hygiene. Item 27 la marked other than other traumatic event, the TO Re Compo		19a. Informant's Name/Relations										er, City or Town		
1 and 2 Health em 27 I		Mrs. Deborah F	. Morri	s (dg	-				Drive	, Ch	urchvi	ele, MD		
it of He	2	20a. Method of Disposition 1 🕱 Burial 2 🗆 Cremation	3 Demovel for	rom State	20b. Place ceme	of Dispos tery, crem	sition (Ner netory or o	ne <i>of</i> other pla	ce)		Date	20c. Location	- City or T	own, State
Pages mant of I ant: If Ite ury or o		4 Donation 5 Other (S		OIII Otate	Park	wood	Ceme	teri	1	17	/21/00	Baltim	ore,	Maryland
permit. Pages 1 and Department of Health Important: If Item 27 any injury or other th once.		21. Signature of Funeral Service	Licensee			22.	Name ar	d Addre	ss of Facility	400	Hama	Tuo		
205 2 2		Buaira	wil	len		3	705	Belo	iir Rd	., E	Home, Baltimo	re. MD	2123	6
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications the	nat caused on each lin	the death. D	o not ente	r the mod	le of dyir	ng, such as	cardiac o	or respiratory a	irrest,		Approximete Intervel Between
Physician			00	101	- 04	- 60			10.0			00 - /	/	Onset and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a. IY	let	WIC	UX) (0	lon	_ (W)	re		1 you
	6				Due to (or as	e consequ	uence ot):						1	
			b		Due to fee a			-					1	
n and ial-try	EXG	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			Due to (or as	a consequ	uence ot).						1	
ficate be executed physician and is the bural-transit medical Examin	20	that withated events	c		Due to (or as	a consequ	uence of):			-		_		
5 9 6	20	resulting in death) Last												
attending government of for use as	200		d										+	
0 0 %	5	Part II. Other significant condition	ons contributing	to death bu	t not resulting	in the un	derlying	ause giv	ven in Part I.		23b. Did	tobacco use c	ontribute	to the cause of deati
d by the etach	T.										1	Yes 2 No	3 Pro	obably 4 Unkno
requires that the een signed by the hould be detache atted by Physe	D.												T 0.41- 14	
been si should should leted	200											en eutopsy ormed?	a	Vere autopsy tinding: vailable prior to ompletion ot ceuse
2 00 0	2				-								0	f death?
cate ha									and the same		10	Yes 2 No	1	☐ Yes 2☐ No
certificate rector, pag	ם ו	25. Wes cese referred to medica examiner?	Hospital:	_				Ott	000		h (Check only			
this aldi		1 Yes 2 No		l Inpatie		Outpatient o. Time of		JA	4LI NU	-	me 5 Res 28d. Describe	how injury occ	ther (Spec urred	ify)
After fune	5	1 Netural 5 Pendir		ete of Injur Month, Day	Year)	Injury	м	28c. Injui Wo 1 □	rk? Yes 2□					
The State	2	3 ☐ Suicide 6 ☐ Could	not be	lace of Inju	ury - At home c. (Specify)	farm, stre	et, factor	y, office			281. Location	(Street end Nur	nber or Ru	rel Route Number,
= 400 =	5	4 Homicide	ь	uilding, etc	: (Specify)						City or To	wn, Stete)		
afferd Direct d in by	7		ng Physician: To											
septal or Attending P hours after death. neral Director: After t y filled in by the funers	ē .	(Check only 2 Medical	Examiner: On the and a	ne basis of manner sta		and/or inv	estigation	, in my c	opinion, deat	th occurr	ed at the time	, date and plece	e, and due	to the cause(s)
ne Hospital or Att in 24 hours after d he Funeral Direct pletely filled in by edical Certifi	POING	one)		1	-	0	29	c. Licens	se number	,		29d. Date ajdr	ned (Month	, Day, Year)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (one) 29b. Signature and title of pentiling	10	1-	and I		1	D 4	1 4			A 472 C		
To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by Medical Certifical	one)	la Ca	a	ude	Rent		D4	14-0	06		07/2	0/2	000	
To the Hospital or Att within 24 hours affect To the Funeral Direct completely filled in by Medical Certifil	2	one)	who completed	ceuse of di	Sath (Item 22	a) (Type, j	Peint)	DA O	140	6	10/1	07/2	0/2	#21221
To the Hospital or Att within 24 hours afferd within 24 hours afferd To the Funeral Direct completely filled in by Medical Certific	2	29b. Signature and title of position	who completed	M.	Sath (Item 22	a) (Type, I	F.C.	DA 90	14-C	RA	NKL	07/2 NSA	Dr	#21237

JUL 2.1 200

Months Days

10f. Zip Code

Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

Brandywine

59

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 23, 2000 REBECCA **SMOOT** 7:48 AM

4b. City, Town, or Location of Death

8. Date of Birth (Month, Day, Year)
Sept. 30, 1

BRANDYWINE

If Under 24 Hrs. Hours Min.

4c. County of Deeth

10g. Citizen of What Country?

PRINCE GEORGE'S

Birthplaca (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 ♥ No

1940 Washington DC

Physician /Medical Examiner

CHARLOTTE

5. Social Security Number

214-40-9418

10e. Street and Number

Usuel Residence of Decedent

19209 CROOM ROAD

4a Facility Neme (If not institution, give street and number)

10b. County

Maryland Prince George's

10 M 20 F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 2 5 2000

31. Date filed (Month, Day, Year)

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hydens. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show eny injury or other treumatic event, the Wedtes Exeminal must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

for use es been signed by the should be detached within 24 hours after death.
To the Funeral Director: After completely filled in by the fur

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

19209 Croom Road				20613			USA	
11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		es Decedent of H Yes, specify Cubi ☐ Yes 2 ※ No	lispanic Origin? (San, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	14. Rac Bled	e-American Inc ck, White, etc. : White	dian,
15. Decedent's Edu (Specify only highest grad		16a. Decede (Give ki life. Do	nt's Usuel Occup ind of work done O NOT use retired	ation during most of wo	orking	16b. Kind of B	usiness/Industry	
12	2	Hor	memaker			0wn	Home	
17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumen	10)	
Ellis Trueman				Gisel	e Johnso	n		
19a. Informent's Neme/Reletionship (T)	vpe, Print)	19b. Mailing	Address (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)
Thomas A. Smoot -		19209	Croom R	oad, Bra	ndywine,	MD 206	13	
20e. Method of Disposition 1 ☐ Burial	temovel from State	tt Crem			7-24-00	Waldorf	City or Town, S	tete
21. Signalulus Funeral Service USA		P.0	.BOX 156	, WALDO	HOME, INC RF, MARYI	LAND 20	0604	
23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. ne cause on each line.	Do not enter	the mode of dyir	ng, such es cardia	c or respiretory e	rest,	Inter	oximate val Between et end Death
Immediate Cause (Finel disease or condition resulting in death)	. Crawer o	8 1	wer				6	nKi
	Due to (or	as a consequ	ence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	G	es a conseque			BAN			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions con	d	ting in the und	derlying cause giv	en in Pert I.				cause of death?
					10	Yes 2 No	3 Probably	4 Unknown
						en eutopsy med?	eveilable	on of cause
					101	res 2 No	1 🗆 Yas	2□ No
25. Was case referred to medical				26. Place of De	ath (Check only o	nne)		
examiner?	lospital: 1 Inpatient 2 E	R/Outpatient	3□ DOA Oth	er: 4 Nursing	Home 5 A Resid	dence 6 Oth	er (Specify)	
27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe i	now injury occur	red	
3 Suicide 6 Could not be determined 29e. Certifier (Check only one) 29 Medical Examile	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stree	et, fectory, office		28f. Location (S City or Tox	Street end Numb vn, State)	oer or Rural Rou	te Number,
29e. Certifier 1 \(\begin{array}{c}\text{Certifying Physical Examination}\) 2 \(\begin{array}{c}\text{Medical Examination}\)	sician: To the best of my know ner: On the basis of examinetic end menner stated.	ledge, death on and/or inve	occurred et the tir estigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and me date and place,	enner as stated. and due to the o	cause(s)
29b. Signature end title of certifier	Talko	70	29c. Licens	e number		29d. Date signe		Year)

DHMH 16 Rev 6/95

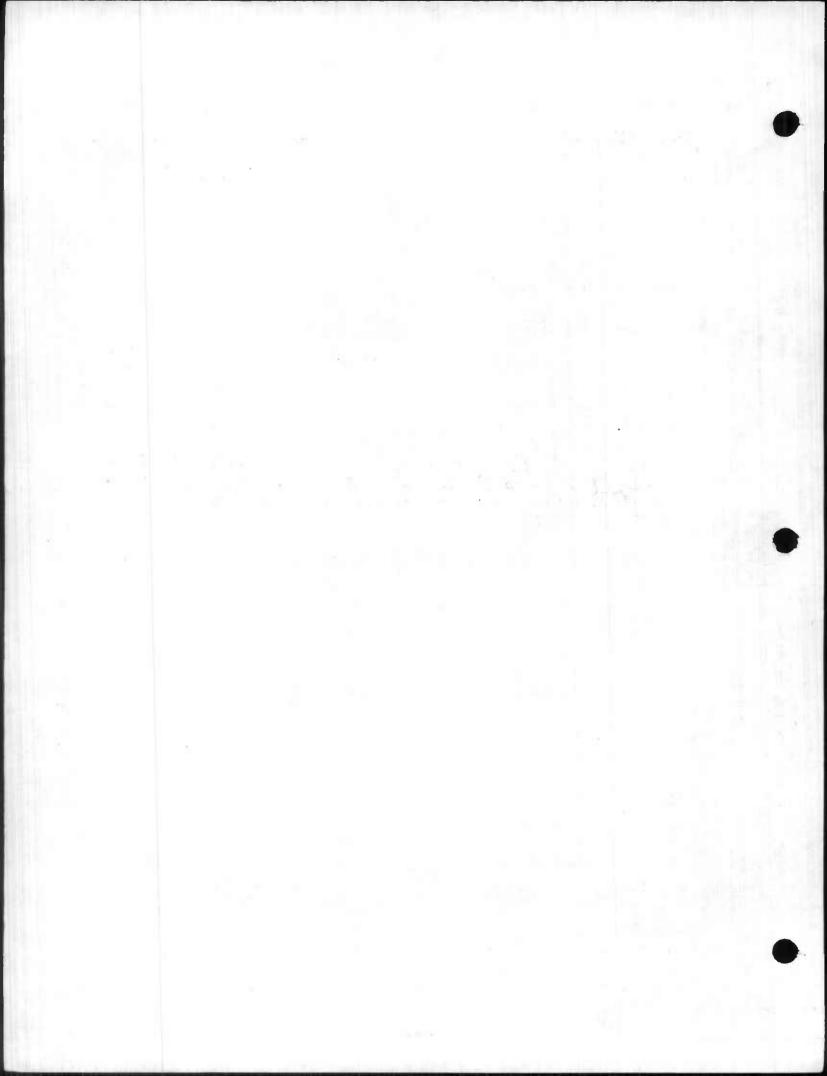
State

Registrar

porks

THOMAS L. FIELDSON, MD, 2068 CRAIN HWY., WALDORF, MARYLAND 20601

32. Registrar's Signature



Piease Type or Print in Black Indelibie ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item #8, per FH,7/27/2000, BG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARIE OZETTA 2000 /Medical 4c. County of Deeth WICOMICO 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1960 2-3-400 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** 1□ M 2 X F Months Days Hours 40 Yrs. 212-72-2187 Usual Residence of Decedent MD Director 10a. State 10c. City, Town or Location 10d. Inside City Limits RIS FIEID MD 1 X Yes 2 □ No DOMERSET Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 U.S.A 21817 109 OVE Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, etc. 1 Never Married 2 Married à 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

EA-TOO 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) METOmpkin Bay Scaled YR 17. Father's Name (First, Middle, Last) 18. Molher's Name (First, Middle, Maiden Sumeme) Maryland All3 IAYLOR 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Someis Cove Risfield nt of Health : If Item 27 MD 21817 KEVON D. MCCREADY -SON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removel from State PEER Cometery 7-29-00 MARion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Fecility

Anthony

E. WARD Funeral Home

314 Cave ST. CR: Sfield, UD 34

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 31817 Approximete Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Cancer una Examiner Due to (or as e consequence of). Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): The law requires that the deeth certificate be execut Due to (or as a consequence of) use as the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown þ of Vitai Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 X No this certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural of or Attending after death. 1 Yes 2 No 2 Accident the 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of cert

State Registrar

JUL 2 7 2000

30. Name and eddress of person who complete CNVIStopher Snyder

31. Dele filed (Month, Dey, Year)

106 MilfWD 516
32. Registrer's Signature

ause of death (Item 23e) (Type, Print)

siect

ORIGINAL

VO.

B. South

H50497

1/21/00.

SAUSbury, MD 21804

4 1 3 CHE NUMBER OF THE 4. SHIRE ALE ASUSAM GARRANTE Bernard One Mr. Charlety John 5 817 Acres D. Markenbyer 2011 MT Personal Comment of Miles Paragraph TM FIRE OIL, NINGER TO THE SECRET

State of Maryland / Department of Health and Mental Hygiene

JULY 18, 2000

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3	00	24	0	L.	2

			Certifica						
	Decedent's Nema (First, Middla, Li	ast)				2. Data of Da Month	ath Day	3. Tir	ma of Death
ysician Medical	CHRISTINE WA	NDA TIBBS				JULY		000 3:	55 am
	Facility Nama (If not institution, gi	va street and number)	(Armilleon)		4b. City, Town, or	Location of Death	4c. County	of Death	
	SHADY GROVE	ADVENTIST	HOSPITAL		ROCKVI	LLE	MON	TGOMERY	7
eral 5. S			s. last birthday) If Und Month	ar 1 Yaer s Days	If Undar 24 Hrs Hours Min.		th v. Year)	9. Birthplaca (S Country)	tata or Foreign
ctor 2	16-22-1033	1□M 2MF 72	Yrs.	Bayo	110010		1928	WV	
	uel Residence of Decedent	140-6	24					Late	d. ob distant
108	. Stete 10b. County		City, Town or Location						de City Limits
M. 10e	D MONTG	OMERY	BOYDS						Tes Zhino
100	. Street and Number		10f. 2	ip Coda			10g. Citizan ot 1	What Country?	
E 1	6824 WHITES S	TORE RD.		2084			U.S.		
e 11.	Maritel Status	12. Was Decedant Ever in Armed Forcas?	U,S. 13. Was Dec	edant of h	lispenic Origin? (S an, Maxican, Puar	specify Yes or No to Rican, atc.)	- 14. Rad Bla	ce - Amarican India ck, Whita, atc.	an,
22	1 Nevar Married 2 Married	1 Yas 2 No		2 No	Specify:		Specif		D
ALC: UNIVERSITY OF THE PARTY OF	3 Widowed 4 Divorced	Yaar or Datas:		/			Specia	, MUTI.	C
ete dica	15. Decedant's E (Specify only highast gr		16e. Decedent's Us (Giva kind of v lifa. DO NOT	ual Occup	ation during most of wo	rking	16b. Kind of B	usiness/Industry	
de E	Elementery/Secondary (0-12)	Collega (1-4or 5+)			d)				
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2 P A	DAM KELLEY LA	MBERT			CARR	IE WILI	IE SMI	TH	
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20a	. Mathod of Disposition		Place of Disposition (Nicematary, cramatory of	ama of	ca)	Data	20c. Location	- City or Town, Sta	ita
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21.	Signature of Euneral Service Lice	4			ss of Fecility		2 112221	(101() 11	
8 8	11/11/1	M			TUNERAL				
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	Part1. Enter tha disease, or conshock, or haert tailura. List only	ona cause on each lina.	atti. Do not ariter trie in	ode or dyn	ig, such es cardia	c or respiratory e	irest,	Integri	Alliete
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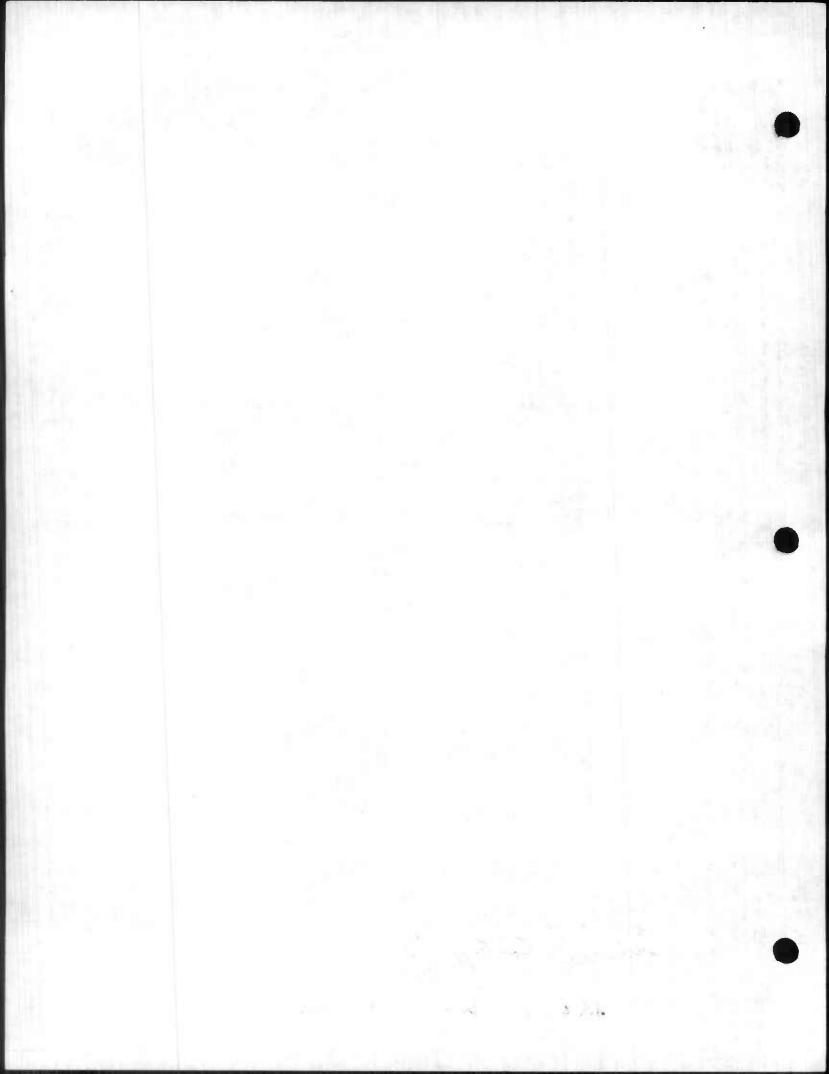
DHMH 16 Rev 6/95

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

SCHOENBERGER, MD

D26540

16220 FREDERICK RD., GAITHERSBURG, MD



State of Maryland / Department of Health and Mental Hygiene

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	5. Social Security Number			7. Aga (In yrs. I	last hirthday	1					vaian
eral ector	549-48-3146	6	™ 2□ F		7 Yrs.	Months Deys		Min. Jan. 2	Day, Year) 28, 1933	9. Birthplace (State or Fo Country) Washington, D	C
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by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	1	12. Was Deced Armed Ford 1 X Yas If Yas, Give Yaar or Da	2□No 19	51-	was Dacedant or If Yas, specify Cut		n? (Specify Yes or I Puerto Rican, atc.)	Bla Specil	ick, Whita, atc.	
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Be C	17. Fether's Name (First,	Middle, Last)					18. Mother	s Nema (First, Midd			
TOB	Robert Tille	ett					Geneva	a (Maiden	Surname	Unknown)	
-	19a. Intorment's Name/R	lalationship (7	ype, Print)		19b. Maili	ng Addrass (Stree	t end Number	or Rural Routa Nun	nber, City or Town	, Stata, Zip Coda)	
	Patricia Pa	rsons/	Stendans	phter	P. (Box 62	6. Heb	ron, Mary	land 218	30	
	20a. Mathod of Dispositio		oropuda	20h PI	lace of Dispo	sition (Nama of		Data		- City or Town, Stata	
	1 Burial 2 XCrail 4 Donation	Other (Spacify)	rara	nbridg	matory or other pla e Cremat	ory			dge, Maryland	i
SUCE	21. Signeture of up and	uch	23e	ller	- 10	6 Main S	treet,	ome, P. O East New	Market,		
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State Registrar

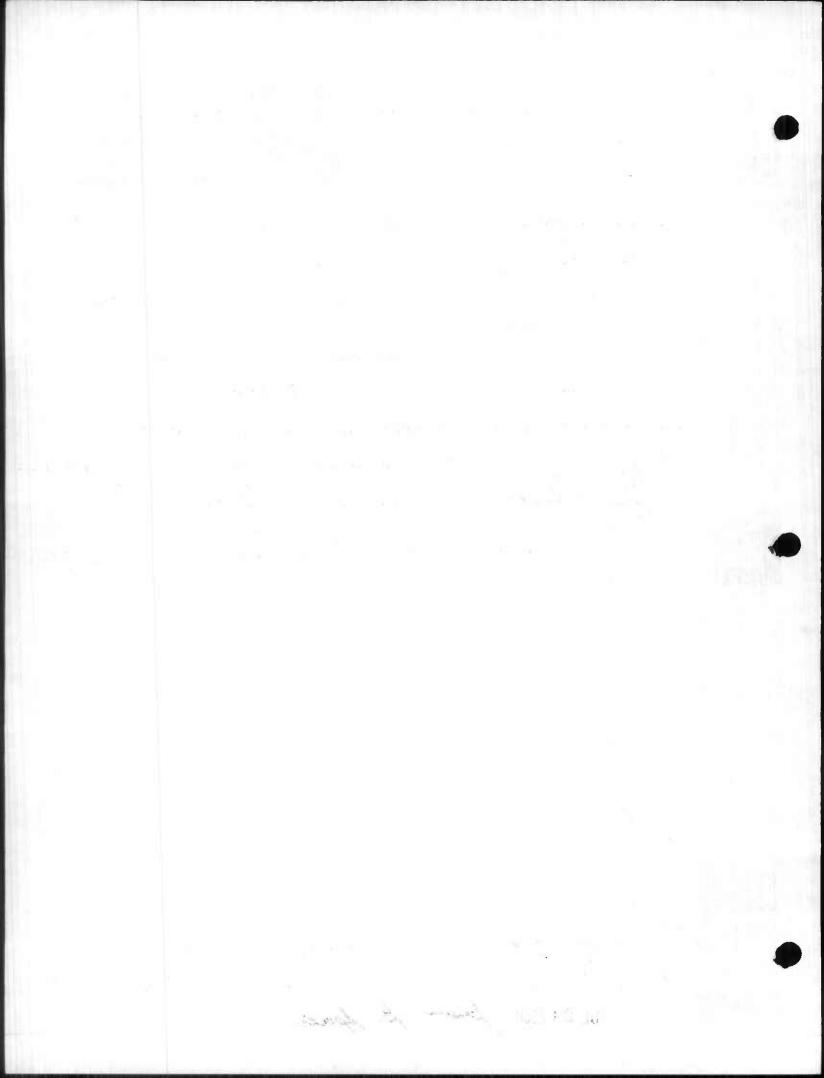
DHMH 16 Rev 6/95

31. Data tiled (Month, Day, Year)

JUL 2 4 2000

march of consult, 100 15 100

		1. Decedant's Name (First, Middla,	Last)					2. Data of D		3. Tima of D
nysician Medical	_	E	BETTY	SUE	THOM	AS		July	23 20	0.0 0915
xaminer	•	4a. Facility Nama (If not Institution,	give street and nu	mber)			4b. City, Town, or			y of Death
	Ŋ.	1005 Rc	slyn A	ve.			Cambri			chester
neral	1	5. Social Security Number 6	S. Sax	7. Aga (In yrs	Moi	Jnder 1 Year nths Days			rth av. Year)	9. Birthplace (Stata or I
ector		214-28-3488	1□ M 2√ F	66	Yrs.				, 1934	Virginia
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be notified Director	8	Maryland Dorch	ester		Cambride	JE of. Zip Code			10a Ottivan of	What Country?
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ner must be notified at	2	1005 Roslyn Ave		edant Evar in 1	U.S. 13. Was [1613 Hispanic Origin? (S	Specify Yas or N	o- 14. Ra	US ce - American Indian,
by F		1 Navar Married Married 3 Widowed 4 Divorced	Armad Fo	orces? 210No va	if Yas,	specify Cub	oan, Maxicen, Puer	to Rican, etc.)		ack, White, etc.
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To		Theodore Wed	dle				Stell	a Alder	man	
W.		19a. Informent's Name/Ralationship	(Type, Print)		19b. Mailing Ad	drass (Straai	t and Number or R	u <i>ral Rout</i> a Num <i>t</i>	oar, City or Town	, State, Zip Coda)
other traumatic ev		James P. Thomas	Husb		1005 Rc	slyn i	Avenue Ca	mbridge	Maryla	and 21613
ar of	1	20a. Mathod of Disposition Mathod of Disposition Care and Care	□ Removal from		Place of Disposition cematary, crematory	(/vama o/		Data	20c. Location	- City or Town, Stata
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any injury or one	100	21. Signature of Funaral Service Lie	ensaa		22. Nan	na end Addra	ass of Facility T	homas Fr		
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State of Maryland / Department of Health and Mental Hygiene

AMEND#3	31	7/14/00 Per Hea	1th Dept cm					Reg. No.	24651
Physic	ian	1. Decedent's Nema (First, Middle, Last					2. Dete of De Month	Day Y	3. Time of Deeth
/Medi Exami	ical	Randolph J. 4e Facility Name (If not institution, give	Thomas street and number)			4b. City, Town, or L	July ocation of Deeti		000 11:00 am
Exami	ner	Hospice of the		Resid		Linthic			e Arundel
Funeral Director	_	210-34-4433	7. Age (In yrs. 4	est birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Bir (Month, De Dec 2(th by, Yaar) 9 0, 1936	Birthplace (Steta or Foraign Country) Maryland
deeth with the Marylend rms 23a or 28e-f show	ctor	Usuet Residence of Decedent 10a. Stata 10b. County MD Anne An		.Town or Local	eville				10d. Inside City Limits 1 ☐ Yes 2 ♣ No
oth with the 23s or 28	Funeral Director	10e. Street and Number 8392 Vineland (Court		10f. Zip Code 21108			10g. Citizen of Whe	et Country?
9 2 2	þ	11. Marital Status 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U,S Armed Forcas? 12 Yes 2 □ No If Yes, Give Yeer or Dates:	1	☐ Yes 2 No			14. Raca - Bleck, Specify:	Amarican Indian, White, etc. White
の音。ま	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation le completed) Cottege (1-4or 5+)		ent's Usuel Occu kind of work done 30 NOT use retire spatche	petion during most of work ed)	sing	16b. Kind of Busin	ng Company
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Mary ind 2 sho eith and N 27 Is me		19e. Informent's Name/Reletionship (T) Geraldine Thoma				and Cour			
Or other		20a. Mathod of Disposition 1 ABurial 2 Cremetion 3 4 Donetion 5 Other (Specify)	Removel from Stata	eca of Dispos emetery, crem	sition (Name of natory or other pla ill Ceme	ace) Ji	uly 15	20c. Location - Cit	y or Town, Stata
Baltim permit. Pa Departmen Important: any Injury page.		21. Signature of Series Service Oceans		22 H	Name end Addr Barranco	ess of Fecility & Sons,	P.A. Se	verna Par everna Pa	k Funeral Home rk, MD 21146
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aw requir	Completed by							en eutopsy primed?	24b. Were eutopsy findings aveitable prior to completion of cause of death?
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Division o To the Hospital or Attending Ph within 24 hours after death. To the Fureral Director: After th completely filled in by the funeral	edical		sician: To the best of my know ner: On tha basis of examineti end menner steted.						
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		30. Name and address of person who con the R. Graze	MD 900 Be	stopi	te Rd=	4 300 A	mape	dis Mi	21401
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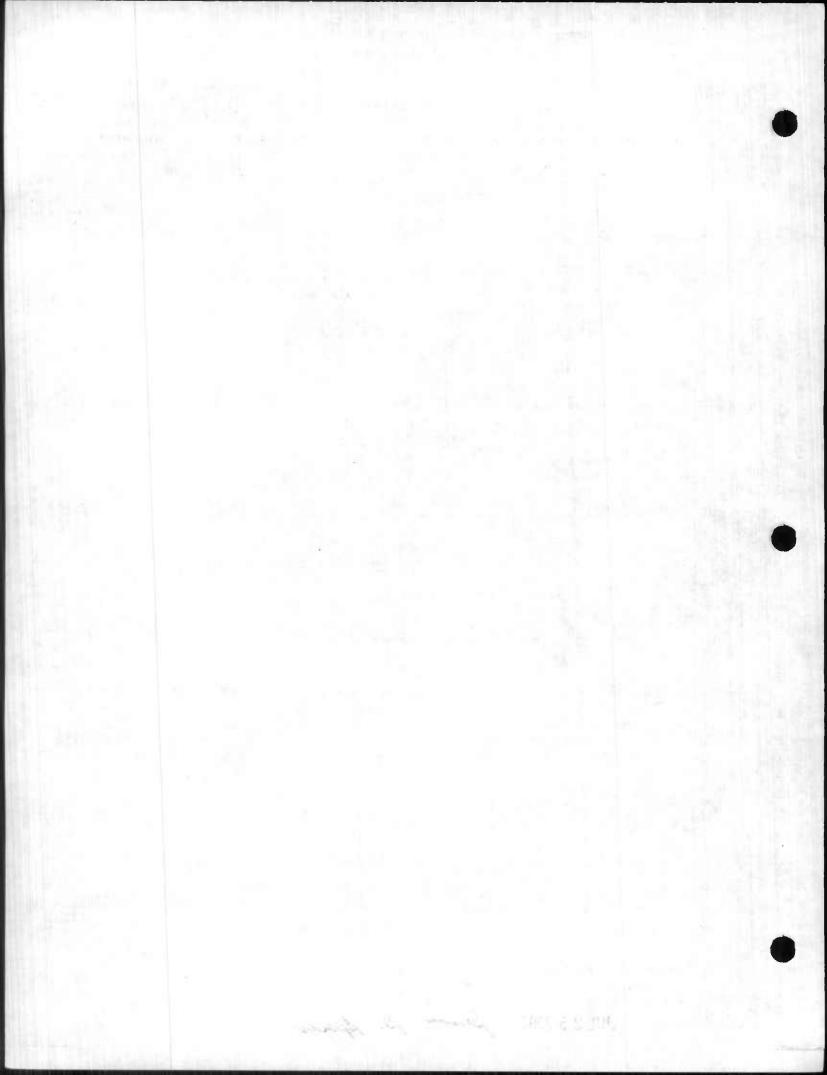
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/Medical Examiner	4a Facility Nama (If not institution, g	ive street and number)				4b. City, Town, o	or Location of Deal		ty of Death	
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irector	236-01-6074	15€M 2□F 85	Yı	Months	Days	Hours M	July 5			Virgini
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oct d	Maryland St. Ma	ry's	Pine	y Point						
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by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑Yes 2 ☐ No If Yas, Giva Year or Detas:	0	1 Yas	1	Specify:		Speci	se	nite
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other traumatic ev	Thomas	Waldro	on			Ida	ı	Waldro	n	
10	19a. Informant's Name/Relationship			Mailing Addres	s /Stroot		Rural Routa Numb			Code)
	Mildred M. Waldro						Point, M			
	20a. Method of Disposition	on (Spouse)	20b. Place of E			, riney	Date	20c. Location		
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			ath (Item 22-) (T	ma Print						
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	Chandra Sajja,	200		потту	wood	, raryr	2003			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 24,653

Maryland Wicomico Salisbury 107.76 Code 109.76 Code 109.77 Code 1			1. Decedent's Name (First, Midd	fle, Last)			121		2. Dete of De		.,	3. Time of Death
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PUNISULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO SALISBURY SALISB			4e Fecility Name (If not institution	on, give street end numb	9r)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
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	To To to Com	2	29b. Signeture end title of certifi	er			29c. Licen	se number		29d. Date signe	d (Month,	Dey, Year)
30. Name and address of person who completed cause of deeth (ttem 23a) (Type Print)			both	au	1. 1	0.0				7/24	100	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Allen M.D. 560 RIVERSIDE DV. A 204 SAUSWIJ, MO 31. Date filed (Month Day Year) 32. Registrar's Signature			30. Name and address of person Robert A	11	deeth (ttem	23a) (Type, F	ide Dr.	A 204	SAUSWI	y no		

DHMH 16 Rev 6/95

Registrar

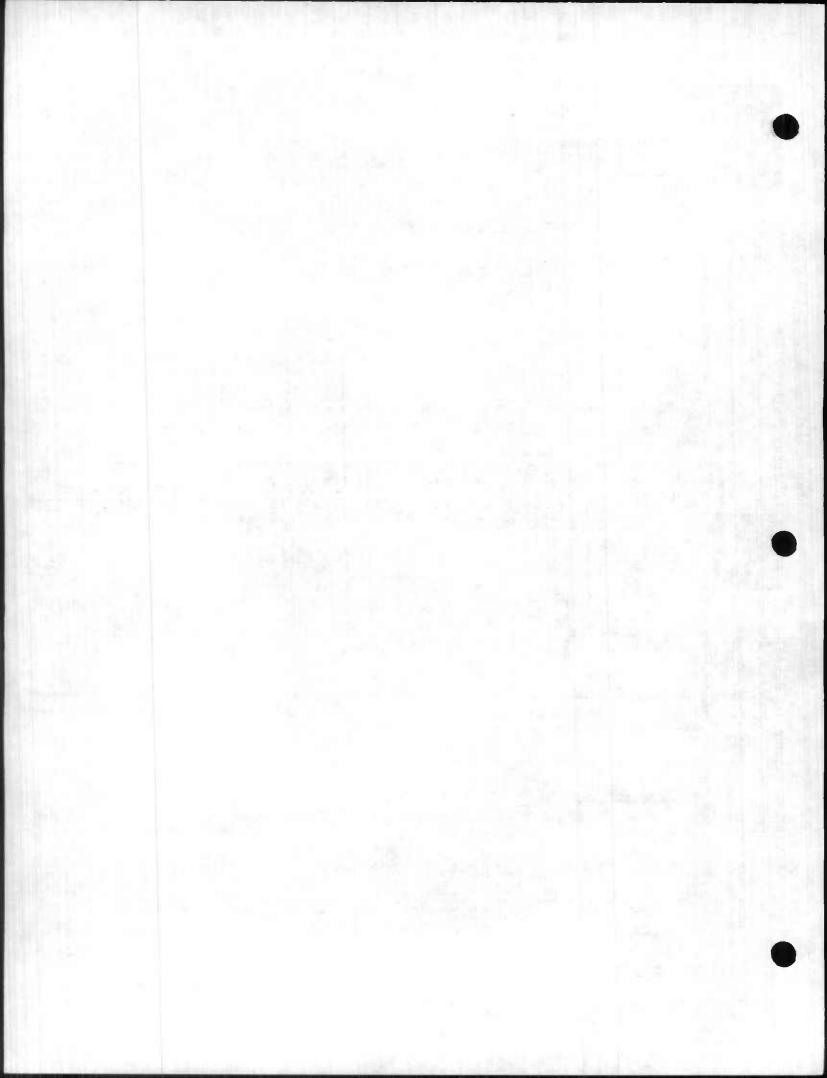


			State	of Maryla		epartme Certifica				lental Hy	/giene (0	24654
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/Medical Examiner	4e Facility Name (CWICZ		- 4	b. City, To		ocation of Dea		nty of Deet	
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Varyi ratho	MD	Howa	Frac		Col	umbia							1 ☐ Yes 20 No
or 28a-t s be notified Director	10e. Street and Nu		alu		CO1		Zip Code		-		10g. Citizen	of What Co	ountry?
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her death r here 23 iner must Funeral	11. Marital Status	an rage	12. Wes D	ecedent Ever in Forces?	in U,S.	13. Was Dec	edent of H	ispanic Or	igin? (Spi	ecify Yes or N Rican, etc.)	o- 14. F		nican Indien,
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2 sho and is ma	19a. Informent's N	lame/Relationshi	p (Type, Print)		19b. N	feiling Addre	ess (Street	end Numb	er or Run	al Route Numi	ber, City or To	wn, Stete, a	Zip Code)
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been si should I										24a. We per	s en eutopsy formed?		Were autopsy findings aveilable prior to
The law require sate has been so page 2 should Completed	-												completion of cause of death?
										1 🗆	Yes 2 N	0	1 ☐ Yes 2 ☐ No
ysician: The is certificate director, pag	25. Wes case reference examiner?		Hospitel:				Oth	or.		h (Check only			11
Physic or this or all dir.	1 Yes 2	rNo th	1 000000		2 ER/Outp		DOA	4 U N	ursing Ho	me 5 Res	sidence 6 kg	Other (Specurred	ocity) HOSPICE
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tal or Attanding P rs after death. al Director: After t led in by the funer: Certification:	4 Homicae		DI.	uilding, etc. (Sp.	есну)					City of To	JWII, SIBIB)		
To the Heapital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (29a. Certifier			the best of my									s steted. e to the cause(s)
the thin 2, the Famplet	ana)	1		anner steted.	0								
o t v t	296. Signature and	mie cycentiller	1	1150	/	2	29c. Licens	e number	1		Date Si	gried (Mon	th, Dey, Year)
10	1	MNO.	nuy	juic	you	0	1d	700	7		1017	00.1	15000
20	30. Neme and add	O To	ho completed o	ause of death (23e) (T)	pe, Print)	Ch .	le-	4	Ra Pa	5 m	× >	1204
State	31. Dete filed (Mon	nth, Day, Year	9-171	Projetrar's Si	ignature A	4.	1	1	,,,,	200	0 101	(A E	(20)
State Registrar		UL 24	2000	Marian	1	. 14	ook.	2					

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020 Phillip Waszkiewicz

Division of Vital Records, P.O. Box 68760,

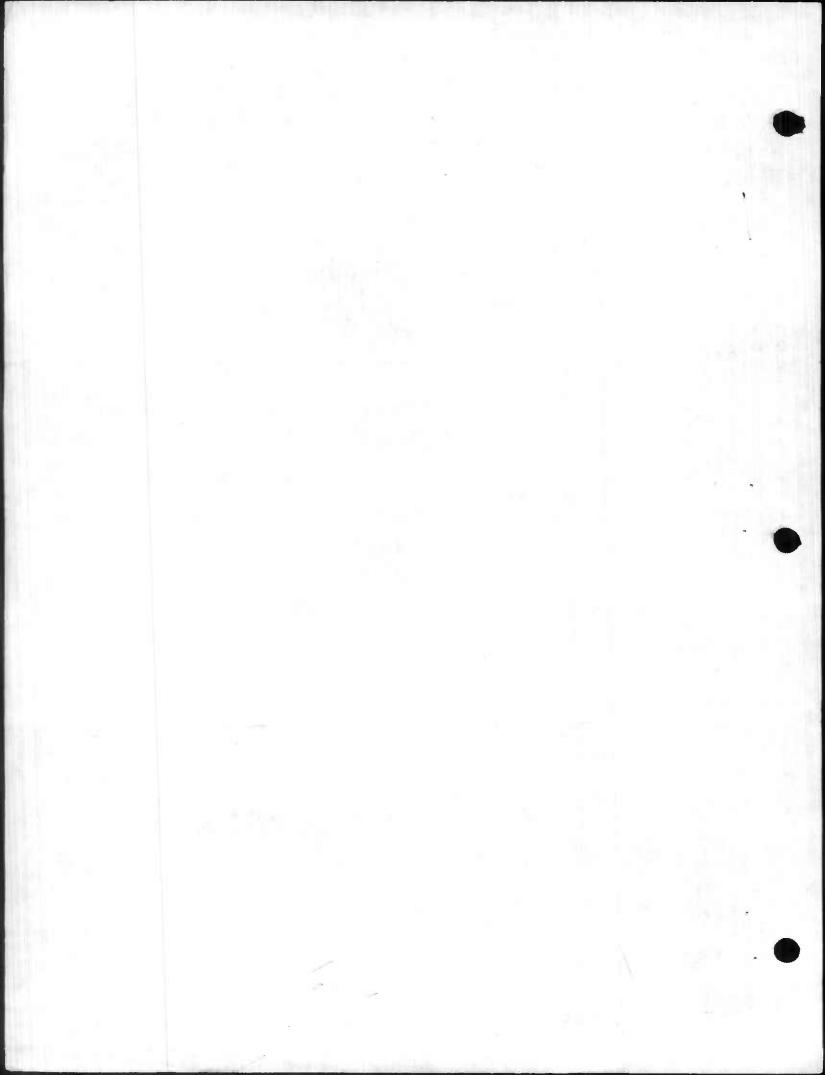


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ald Cole W	lare Jr.			State	of Maryla	and / Department of Health an	d Mental Hygiene	JU	2460
AMEND ITE	MS: #23	PART I	, II,	27 E	PER MEO	and / Department of Health an G786 Certificate of Death	Ban No.		

	Decedent's Name (First, Middle)		120 070	P	incate of	Death	2. Date of Dea	th		3. Time of Death	
Physician /Medical	Donald	Cole		are		Jr.	Month July	30 2	Yeer 000	06:18 A.	
Examiner Funeral Director	527 5. Social Security Number 217 - 74 - 8749	National		oirthday) _ Yrs.	If Under 1 Year Months Days				lega	aca (State or Forei	
,	Usual Residence of Decedent										
28a-f show- nothing at rector	MD 10b. County	Legany	10c. City, To	LaV					10	od. Inside City Limi	
23a or 28a-f unt be notified	10e. Street and Number 527 1/2 Natio	onal High	al Highway					10g. Citizen of WI USA	nat Count	try?	
or items	11. Marital Status 1 Never Married 2 Marr	Armed Force ied 1 Yes 2	1 Yes 2 No				an, Mexican, Puerto Rican, atc.)			ace - American Indian, lack, White, etc.	
		Year or Date		a Doesde	ant's Havel Ossu	ection		16b. Kind of Business/Industry			
then then omp	15. Deceden (Specify only highes Etementary/Secondary (0-12)	college (1-4)	or 5+) i1	(Give k life. D	Decedent's Usual Occupation (Gird kind of work dona during most of working (life. DO NOT use retired) DNWOYKEY			Local #			
18 9	17. Father's Name (First, Middle, Last) Donald C. Ware, Sr. 18. Mothar's Name Phyllis							e (First, Middle, Maiden Sumame) (Young)			
traumatic av		Beth A. Ware (Type, Print) 193 Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code), 194 National Highw; LaVale MD 21502									
ant of Heelth It: If Item 27 i	wife 20a. Mathod of Disagnition 1 Burial 2 Decramation 4 Decration 5 Of the /S		ceme	tary, crem	ition (Nama of atory or other pla		Date 8/06/	20c. Location - C			
Department of Important: If it any Injury or once.	4 Donation 5 Other (Specify) Scarpelli Funeral Homes/06/ Cres Scarped 1: Funeral Homes, P Cumberland, MD 21502									11, 140	
	23a Part1 Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do					rast,	-	Approximate tntarval Batween Onset and Death	
ysician Medical aminer	Immediate Cause (Final disease or condition resulting in death)	a	CARDIA Dua to (or as	Seed 1	PERTROP	НУ			1 1		
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	FATTY LIVER							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkr			
been sign should be							24a. Was perfo	an autopsy med?	avi	era autopsy finding allable prior to mpletion of causa daath?	
pege 2							150	res 2□No		4Yas 2□ No	
certificate rector, peg	25. Was case referred to medica					26. Placa of Dea					
	axaminer? N☐ Yes 2☐ No	Hospital:	atient 2 ER/	Outpatient	3 DOA O			ienca 6 DOthe	r (Specifi	y) Scene	
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within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifyin (Check only one) 2 Medicat	g Physician: To the be Examiner: On the basi and mannar	s of examination	ige, death and/or inv	occurred at the testigation, in my	ime, data and place opinion, daath occu	, and dua to tha rred at the tima,	cause(s) and mar data and place, e	nner as si nd dua to	tated. the cause(s)	
within To the comp	29b. Signature and title of certifie	1001			29c. Licer	se number		29d. Date signed	(Month,	Day, Year)	
	· Dermis	1. Chutero				O.C.M.E.		July	y 31	, 2000	
	30. Name and address of person Dennis J-	Chute no				et, Balti	more, Ma	aryland :	2120	1	
State Registrar	31. Date filed (Month, Day, Year)		istrar's Signature	. 1	5 Los	uls					



State of Maryland / Department of Health and Mental Hygiene 00 24556

			Ce	rtificate of	Death		Reg. No.	0	- 4000		
	1. Decedent's Name (First, Middle, L.	eath	3. Time of Death								
Physician	Pichard Dalo	Witt	July	15 2	Year OOO	8:15 PM					
/Medica Examine	de Facility Name (If not institution of			4	4b. City, Tow	m, or Location of Dea			00.0		
Examine	Genesis Elder	Care - The	Pines		Fac	ston	Ψa	lbot			
Funnit			yrs. last birthday	If Undar 1 Year	If Under 2	4 Hrs. 8. Date of B			place (State or Foreign		
Funeral Director	217-34-9329	txDM 2□F 60		Months Days	Hours		21, 193		aryland		
	Usual Residence of Decedent					Ψει. 2	21, 100	J 11	aryrana		
with the Maryland a or 28a-f show the notified at	10a. State 10b. County	10c	City, Town or L	ocation				1	Od. Inside City Limits		
Men.	Maryland Tal	bot		Cordov	-				1 ☐ Yas A No		
the M	10e. Street and Number		10g. Citizen of What Country's								
frer death with the Ma r frems 23s or 28s-fa	31053 Skipton	Cordous Pd		21	625		U.S.	7\			
death mm 23	11. Marital Status			1		in? (Specify Yes or N		ce - Americ	en Indian,		
ter d	1 Never Married 2 Married	12. Was Decedent Evar i Armed Forces? 1 ☐ Yes 2 ☑ No		It Yes, specify Cube	an, Mexicen,	in? (Specify Yes or N Puerto Rican, atc.)	Bla	ck, White,	etc.		
	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Detes:		1 ☐ Yes 2₺ XNo	Specify:		Specif	y: Wh	ite		
-Oo-		1	16a. Dece	edent's Usual Occup	pation	100	16b. Kind ot 8	Jusiness/Inc	dustry		
715- in 72	(Specify only highest gr	ade completed)	(Give	b kind of work done of DO NOT use retired	during most	of working					
d 21215-0 filed within 72 ho Hygiene. wher than "nature ant, me Medical	Elementary/Secondery (0-12)	Elementary/Secondery (0-12) College (1-4or 5+)					Const	ruct	uction		
	17. Fathar's Name (First, Middle, Las	t)		ywaller	18. Mother	's Neme (First, Middl					
T Selection of						Frances (To ala				
Tyle hould d Mer marke	Robert W. Wit		19h Mail	ing Address /Street		r or Rural Route Num		State Zir	Code)		
Mar Mar Mar Mar Mar Mar Mar Mar Mar Mar											
	Robert L. Witt			osition (Name of	n Cor	dova Rd.	20c. Location		MD 21625		
Peges 1 er	1 Durial 2 □ Cramation 3		cametery, cre	matory or other place	ce)	7/18/00					
	4 Donation 5 Other (Speci	11 27		1.Church			Mayo	, MD			
Baltii permit. P Departm importar any inju	21. Signature of Funeral Service Lice	insee from		2. Nama and Addra			. 1				
m goesa	Jodd	delle	2	onn M.	Taylo	or Funera	ar Home	3	11- ND		
	23a. Part1. Enter the disease, or corshock, or heart tailure. List only	nplications that caused the	death. Do not en	nter the mode of dyir	ng, such as o	cerdiec or respiretory	errest,	Anna	Approximate		
Physician	SHOCK, OF Healt tailule. List on							1	Onset and Death		
/Medical	Immediate Cause (Finat	u Con	cor	1	Le mos.						
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	Immediate Cause (Final disease or condition resulting in death) Non Small Cell Lung Correct Lung correct Countries of Correct Countrie										
60, be executed clan and bunal-trensit	Commentative that conditions	V	Due to (or as a consequence of):								
exacu	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury			.,							
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O. of the described	Part II. Other significant conditions		_	undarlying cause giv	ven in Part I.				o the cause of death?		
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ords, P				1		240 14/0	is an autopsy	Zah W	ere autopsy tindings		
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Recorded to the second							/	of	death?		
The le						10	Yes 2000	1[☐ Yes 2☐ No		
E 12 0	25. Was case referred to medical examiner?			1 -		of Death (Check only	r one)				
- S 00 2	1 Yes 2 No		2 ER/Outpatie		4 LIF NUI	rsing Home 5 Re			(y)		
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Oivision or Attending after deeth. Director: After In by the fune	2 Accident Invastigation	on		M 1 🗆	Yes 2 1	No					
Divisi	3 Suicide 6 Could not detarmined	286. Place of injury - /	28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)				
Division of the or Attending P as after deeth. al Director: After the deet in by the funers		building, oto. (op	outy)								
Hospital 24 hours Funeral ietely filled	29a. Certifier 1 Certifying P	hyelclen: To the best of my									
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	(Check only 2 Medical Exa	miner: On the basis of exam and mannar stated.	ninati <i>on</i> and/or ii	nvastigation, in my o	pinion, deat	n occurred at the time	e, date and place	, and due to	o trie cause(s)		
To the Vithin 2 To the comple	29b. Signature and title of cedarat	1		29c. Licans	se number		29d. Date sign	ed (Month,	Day, Year)		
	MASO	ung)		#4	258	57 mg	07/	(71	00		
	30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)			- 1				
	7	Schilling 0	(item 23a) (Type	- 1 6 1	non's	la Ea	ston m	1 2	1601		
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State Registrar	*****	The second secon	a B	. door	de						
3	00L 10										

JUL 18 2000 - 10

State of Maryland / Department of Health and Mental Hygiene 00 24657

				Certifica	ate of	Death		Reg	. No.			
	1. Decedent's Name (First, Middle, L	nst)						e of Death	Davi	Vans	3. Time of E	eath
Physician	WILLIE L. WH	ITE					JUL		2000	Year	9:30	an
/Medical	4a Facility Name (If not institution, gi					4b. City, Town	n, or Location of	of Deeth	4c. County	of Death		an
Examiner						TATO	C MITT	C	דעם	TIMOF	T C	
	331 KEARNEY D 5. Social Security Number 6.		ge (In yrs. last birth	day) If Unc	ier 1 Year	If Under 24	S MILL	e of Birth	DALL			Forein
Funeral		4 (3)04 2 (C) E	54 Y	Month		Hours		oth Day Y	1936	Coun	lace (State or try) LAND	rororg
Director	218-36-6959 Usual Residence of Decedent		34				UAIN	. 0	1930	PIAINI	מאמע	
pue *	10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City	/ Limits
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the Marylen r 28a-f ehow room at at lrector	MARYLAND BALTI	MORE	OWING		LLS Zip Code			T 45	O'' 41			
vith the Ma t or 28a-f e b roof Director	10e. Street and Number			100	. Citizen of		try r					
death with the Maryland ms 23a or 28s-f show result be notified at neral Director	331 KEARNEY D	RIVE		2.	1117				US			
fler death v	11. Maritel Status	12. Wes Decedent Armed Forces?		13. Was Dec	cedent of F becify Cubi	lispanic Originan, Mexican, I	in? (Specify Ye Puerto Rican, o	s or No- etc.)		ce - Americ ck, White,		
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by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:		12 100	2 (22 10	Ороспу.			Specin	,		
72 hours natural', ocal	15. Decedent's E		16a. D	ecedent's Us	sual Occup	ation during most o	of unding	16	b. Kind of B	usiness/Inc	dustry	
C 1 100	(Specify only highest gi	College (1-4or	i	ife. DO NOT	use retire	d)	or working					
omp	6th	0		CRET	E FI	NISHE	R	A	C DRY	WALI	CO.	
d other avent, r	17. Father's Name (First, Middle, Las	t)					s Name (First,	me (First, Middle, Maiden Surname)				
Mental Me	PAUL WHITE		P				PAULINE BRANI			DEORD		
and Manual Manua	9e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route I											
		(ARVIN WHITE (SON) 404 MORNINGSIDE DR. GLEN BUR										61
of Heelth Item 27 other to	20a. Method of Disposition	5011)	20b. Place of E				Date	-	c. Location			
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Department of important: If any injury or adde.	21. Signature of Funeral Service Lice	ensee MOO4	83			ss of Facility		אוזשמ	DV I	7 7		
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M	shock, or heaft failure. List only	y one cause on each li	ine.							1	Onset and D	
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Examiner	Immediate Cause (Final disease or condition resulting in death) a. Metastatic nors multicell long cancer										6 ma	aff
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een signed hould be del							24	a. Was en	eutopsy		ere autopsy fir	
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r death. cr death. by the funei	1 Natural 5 Pending 2 Accident investigation		28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury 28c. Injury at Work? M 1 Yes 2 No				0					
To the Hospital or Attending Printin 24 hours effer death. To the Funeral Director: Affect completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not	28e. Place of In								ber or Rure	al Route Numb	ber,
erti in t	4 Homicide	building, el	c. (Specify)				Cit	y or Town,	State)			
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n 24 hound he Funer pletely fill edical	(Check only one)	miner: On the basis of	f examination and/	or investigati	on, in my o	ppinion, death	occurred at the	e time, date	e and plece,	, end due to	the cause(s)	
within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		and menner st	ated.		On Hissan			000	Data sina	ad (Manth	Day Vacel	
T 000	29b. Signeture end title of certifier	1 /			29c. Licens			290	I. Date signe	ea (Month,	Day, Tear)	
	Un 91/2	erlane !	mo		022	782		0	h hy 1	8,20	000	
	30. Neme and eddress of person who	completed cause of	death (Item 23a) (T	ype, Print)		- 4	Threety 1		,			
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0	31. Date filed (Month, Day, Year)	32 Bariete	rar's Signature	1 -00	11/4	710000	way	201/17	7- 40-14	1116	Jun 21	200
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John Sharp Wherry JULY 19, 2000 7:20 AM /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM RY POINT PERRY If Under 24 CECTI. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F Yrs. 75 220-20-2555 JAN 2, 1925 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show. the Marylar 1 Yes 2 □ No Directo 288-1 Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21921 105 Park Circle United States Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 1 ☑ Yes 2 ☐ No World If Yes, Give War II Year or Dates: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Heating/Air Elementery/Secondery (0-12) College (1-4or 5+) Conditioning Laborer 12 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 and Mental Lo Eri C. Wherry Eva L. Thompson and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) B sportant: if item 27 ny injury or other to Olive Murphy/Sister 105 Park Circle, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata Date Pages ъ 1 XBurial 2 Cramation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Friends Burial Grounds 7/22/00 Calvert, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton St., Elkton, MD 21921 Jones U es 17 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) 2 DAYS a. ACUTE MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): Examine physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medicai Due to (or as a consequence of): 88 1880 Part II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Part f. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 1 Unknown signed t Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed page 2 s The 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 5 Pending invastigation the Hospital or Attending 1 □ Yes 2 □ No death. 2 Accident after deatl Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 | Homicide filled in t within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of confile 29c. License number 29d. Date signed (Month, Dey, Year) D42800 JULY 19, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 3+1VA THOMAS BIONDO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

JUL 2 1 2000

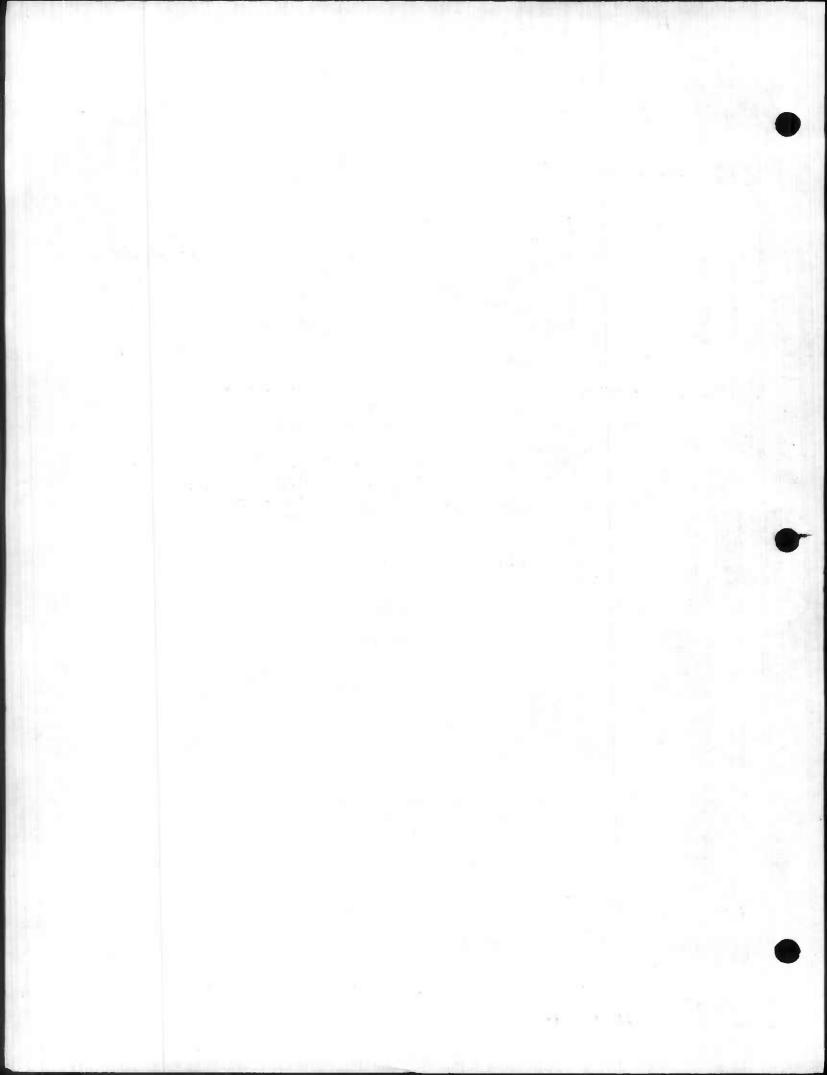
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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-		1 Decedents Name (First Middle Le	-41	Cei	rtificate of	Death		g. No.				
Physic	ian	1. Decedent's Nama (First, Middle, La Lillian Cather					2. Dete of Deeth Month		3. Time of Deeth			
/Medi		4e. Fecility Neme (If not institution, giv				4b City Town or I	July 18		8:55 AM			
Exami	ner	1004 Tamworth Ro				4b. City, Town, or Location of Deeth Bel Air Harford						
Funeral		5. Sociel Security Number 6. S		n yrs. last birthdey)	If Under 1 Yeer	If Under 24 Hrs.						
Director		218-18-2657 Usuel Residence of Decedent	□M 2\ F	76 Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Day, April 2	, 1924	Birthplece (Stete or Foreig Country) Maryland			
show		10a. Stete 10b. County	10	c. City, Town or Lo					10d. inside City Limits			
n the Marylar r 28a-f show	to	Maryland Harford Bel Air							1 ☐ Yes 2 🔀 No			
With on the second	Funeral Director	10e. Street end Number 1004 Tamworth			10f. Zlp Code 210	15	109	g. Citizen of Whe USA	t Country?			
ter dea		11. Maritel Status 1 □ Never Merried 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:			lispenic Orlgin? (Sp en, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Bleck, V	American Indien. White, etc. White			
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1 and Haalth em 27		Milford F. Wolf,				Way, Bel		21014				
ant o		20e. Method of Disposition 1 \(\mathbb{D}\) Burlel \(2 \mathbb{D}\) Cremetion \(3 \mathbb{D}\) 4 \(\mathbb{D}\) Densition \(5 \mathbb{D}\) Other \((5 \mathbb{D}\))	Hemovei from State		osition (Name of metory or other plea Memorial	Gardens 7	115-11	oc. Location - City Bel Air,	SELECTION IN			
permit. Pa Departmar Important: any Injury once.		21. Signature of Funeral Syrupa American Signature of Funeral Syrupa American										
		50 W. Broadway Street, Bel Air, MD 21014										
Dhoolalan		23 Part 1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximation of dying, such as cardiac or respiretory errest, interval Brooks, or heart feiture. List only one cause on each line.										
Physician /Medical		Immediate Cause (Finel disease or condition rasulting in deeth) 8 MoNTA										
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tha de	ysic	Part II. Other significant conditions of	eant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contributa to the cause of deat				
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The law ata has b paga 2 s	d L							4	of death?			
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Physician: Tha lav this cartificata has ral director, paga 2	To Be	examiner?	Hospitel:	o □ EB/Outpotion	Oth		h (Check only one)		0.041			
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or Attend ttar daath irector: , n by tha	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be datarmined										
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the H in 24 the F	edica	one)	iner: On the basis of exa and manner steted.		vestigetion, in my o	pinion, deeth occur	ed et the time, dat	e end place, end	due to the cause(s)			
of the most	×	So. Signiture and title of certifier	51.0	2-11	29c. Licens	se number	290	d. Date signed (N	fonth, Day, Year)			
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		1000	0.000		9	21/13	V)	ac y	10000			
10		30. Namy and address of person who o	completed cause of death	(Item 23e) (Type,	Rrint)	112 SER AUSTON	AR RE	24 CAN	21047			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month **Physician** Lola Ruth Wyatt 19 2000 8:00am July /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1622 Swallow Crest Dr. Apt G Edgewood Harford par If Under 24 Hrs. ys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Virginia Director 203-24-8900 80 12/29/1919 Usual Residence of Deceden The Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Harford Edgewood herre 23a or 23a-finer must be notifie 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 21040 USA 1622 Swallow Crest Drive Apt G Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ital Hygiene. Id other than "natural", or lien event, the Medical Examinar. Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 ahould be fill ment of Health and Mental Heart of Health and Mental Heart of the marked oth lury or other traumatic even 89 Andrew Taylor Laura Hart 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Wyatt- Son 3912 Old Federal Hill Rd., Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 7/21/00 Havre de Grace, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 21078 Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 23a Furt) Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical 8 mo metastatic Colon Caucen Examiner Due to (or as e consequence of) Examine The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Box 68760. physicien the burial Physician/Medical Due to (or es a consequence of): 080 ō signed by the at d be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records. by Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 PNo After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Hospital or Attanding 24 hours after death.
 Funeral Director: After 19 per 19 1 ☐ Yes 2 ☐ No 2 Accident To the Hoepital or Attar Within 24 hours aftar dar To the Funeral Director completely filled in by th 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture nd title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M.D. D45390 7/19/2000 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR # 200, BALTOMORE, MD 21237 Med (A.D.) 6830

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State

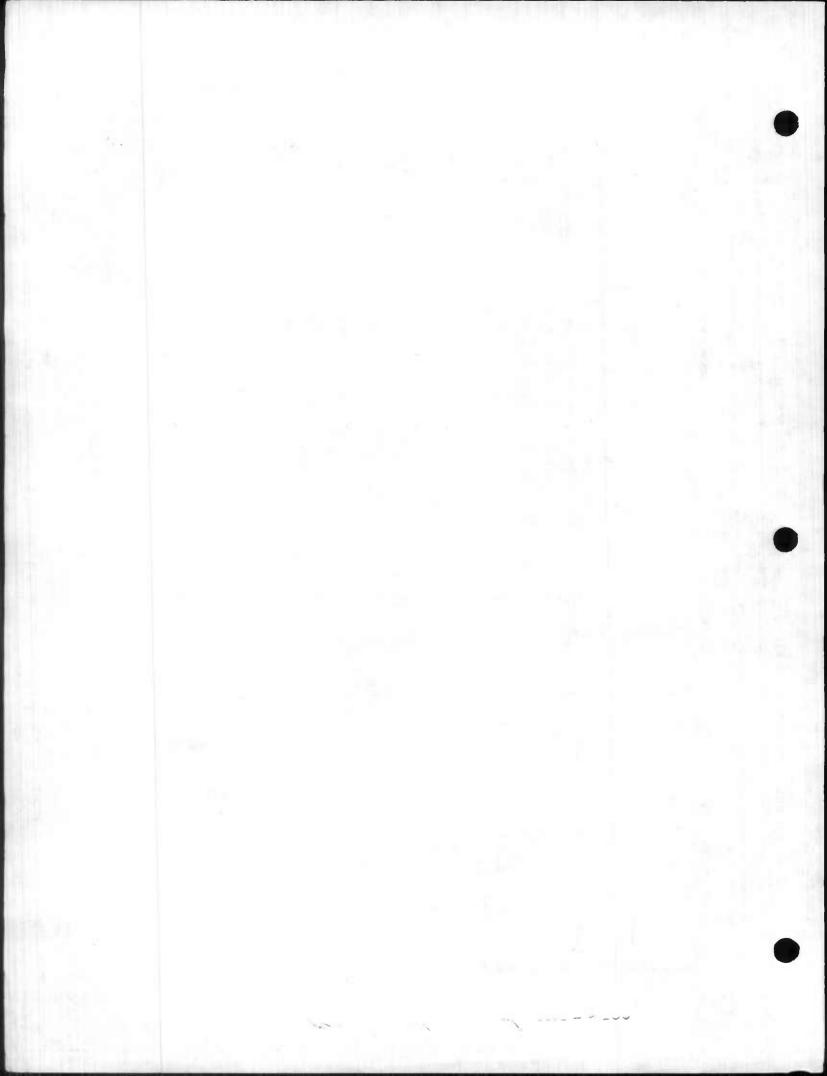
Registrar

31. Date filed (Month, Day, Year)

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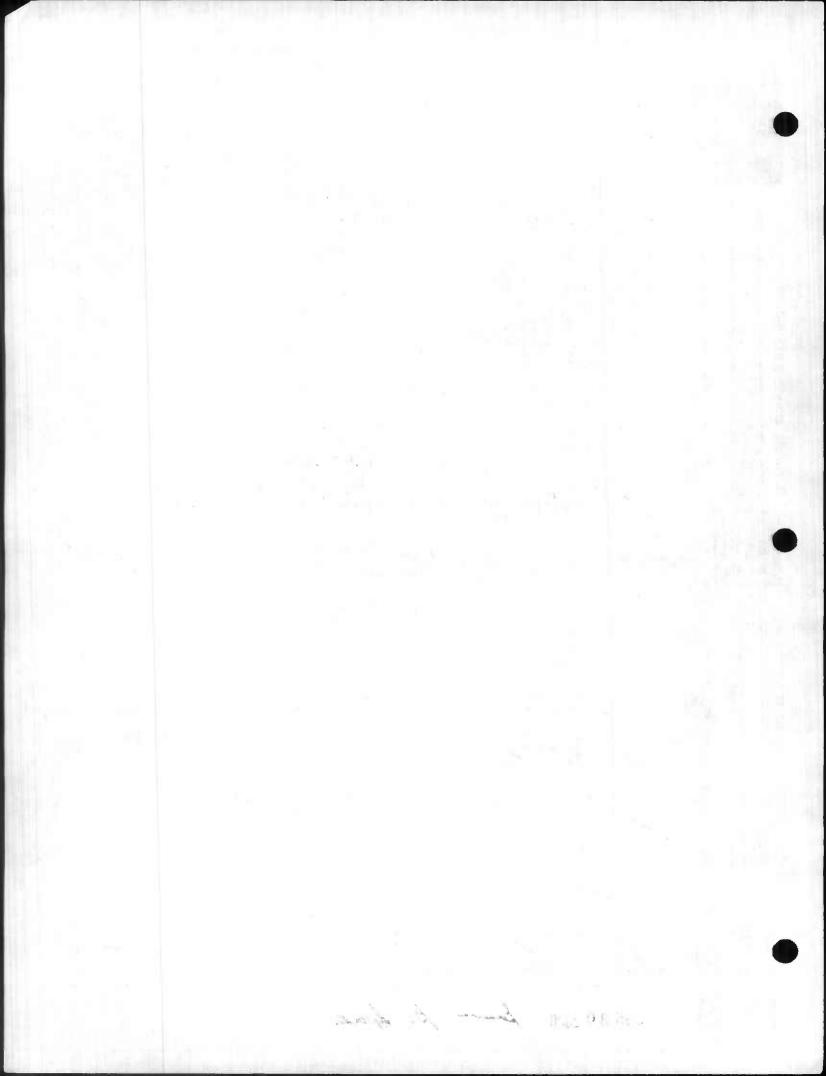
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27, Llovd Percy Zeigler June 1:20 PM /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Months Hours 180 M 2□ F 076-12-3275 September 9, 1919 South Carolina Director 80 Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits man be notified at 1 Yes 2 No Director Maryland St. Mary's Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20659 USA 25825 Hills Drive Funeral Herna 2 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 21215-0020 ŏ 1 Yes 2 No Specify: Specify: þ White 3 ⊠ Widowed 4 □ Divorced Yeer or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Carpenter 12th Grade Union Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I int: If Item 27 is marked of Jasper Zeigler Gertrude Arsula Oxner Henry 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 25825 Hills Drive, Mechanicsville, Maryland 20659 David Zeigler (Son) If item 27 or other 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State Department of Important: If any injury or another 4 ☐ Donetion 5 ☐ Other (Specify) Trinity Memorial Gardens!7/6/2000 Waldorf, Maryland 21. Signature of Funeral Service Lice 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 plications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Approximete intervat Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner ician and burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical physi the b Due to (or es e conseguenca of): 88 use Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 500 The law requires 24b. Were autopsy findings evailable prior to Completed 24a. Wes an eutopsy completion of cause of death? page 2 1□ Yes 20 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 ☐ Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide Hospital Contifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one) within 2 ro the 29d. Dete signed (Monyl, Day, Year) 29b. Signature and title of certific ul 30. Name end address of parson who completed cause of deeth (Item 23e) (Type, Print) Peabody Street, Leonardtown, Maryland 20650 David Federle, 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JUN 3 0 2000

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar 0400 JOHN J. ZAHNER 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Fallston General Hospital Fallston Harford If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) April 3, 1927 If Under 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Months 1♥ M 2□ F Maryland 73 Yrs 219-22-2071 Usual Rasidance of Dacedani 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 426 Moores Mill Road, Apt. 1C 21014 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced Yaar or Datas: 1950-52 White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Etamantary/Secondary (0-12) Cotlega (1-4or 5+) Unknown Lab Technician Healthcare Industry 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middla, Meidan Sumama) George Zahner Catherine Diehl 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiting Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 426 Moores Mill Road, Apt. 1C, Bel Air, MD 21014 Carlyn E. Woerner (Friend) 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 Buriat 2 □ Cramation 3 □ Ramovat from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem. 17/20/00 Baltimore, Maryland 22. Nama and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signatura of Funaral Sarvice Licensee 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition resulting in daath) a. Adeno caranoma 6 Months. Bone meta sitasis nant pleural Sequantially tist conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Diseese or injury that initiated events rasulting In death) Last Dua to (or as a consequence of) Femoral-Popliteal Vein Thrombosis Right Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 NO 1 Yas 2 No 25. Was casa ralarred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 5 Pending Invastigation 1 Naturat 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Sulcida 28a. Ptaca ol Injury - At home, larm, street, lactory, office building, atc. (Specify) 28I. Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide

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Examine Examiner Physician/Medical bengis be det þ Completed Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifies. Be Medical Certification: To

Physician

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Department of Health and Merial: Hy
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Physician

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Baltimore, Maryland 21215-0020

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State

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) PAREKH MD.

29b. Signatura and tiffa of certifiar

1908 HARFORD 32. Asgistrar's Signatura

2000

ROAD PACISTON, MD. 21047

Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. Licanse number

D18424

29d. Data signed (Month, Day, Year)

JULY-14-2000

Registrar

29a. Cartifiar

(Check only one)

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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1304 Unio	n Avenue				Bal	timore		7	J / A	
Funeral			e (In yrs. last bi	Months	or 1 Year Days	If Under 24 Hrs Hours Min	8. Date of Birt	th ly, Year)	9. Birthple	Ace (State or Foreigny)	
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	23a. PartT. Enter the disease, or or shock, or heart failure. Upt or	emplications that caused	the death. Do	not enter the mo	de of dving	a cuch ac cardia	o or respirators a			Approximete	
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/Medical Examiner	disease or condition resulting in deeth)	b	Or Of Due to (or the a	Tonque consequenca of	e an			rrest, 212	1.1	Interval Between	
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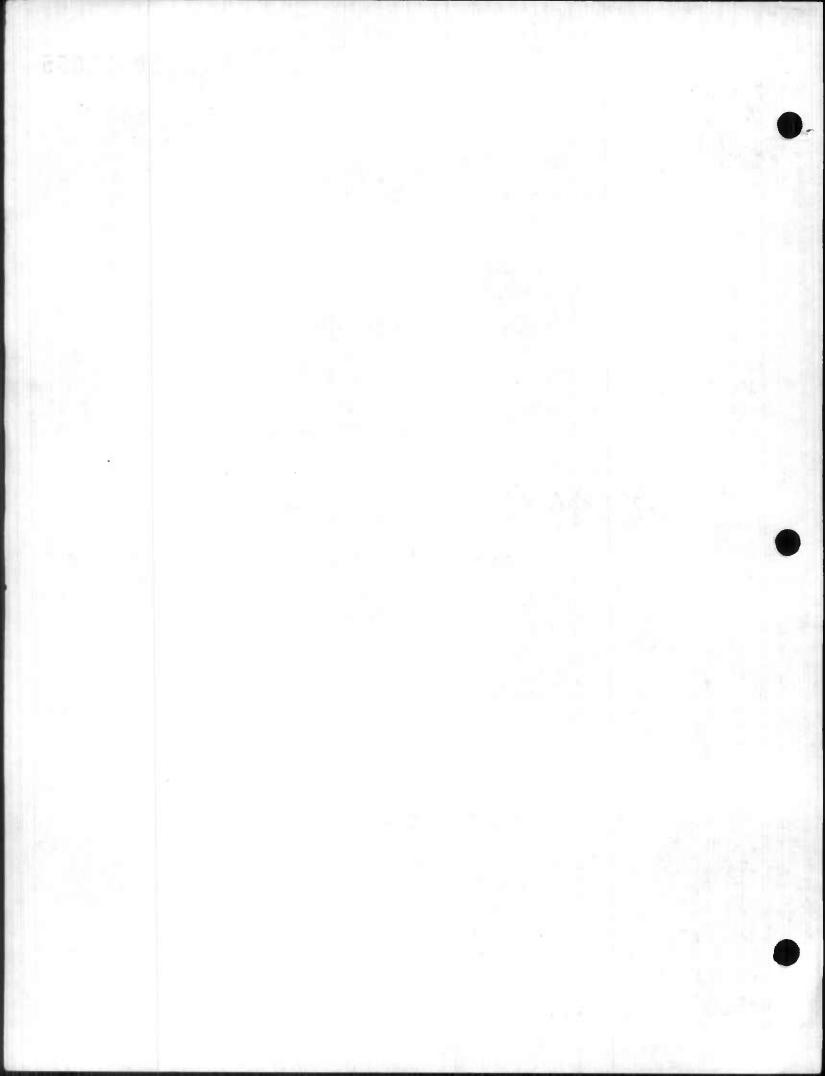
State of Maryland / Department of Health and Mental Hygiene 00 24664

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State Registrar	31. Data filed (Month Day, Year)	32. Registrar's Sign	natura &	Soon	163			

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State of Maryland / Department of Health and Mental Hygiene

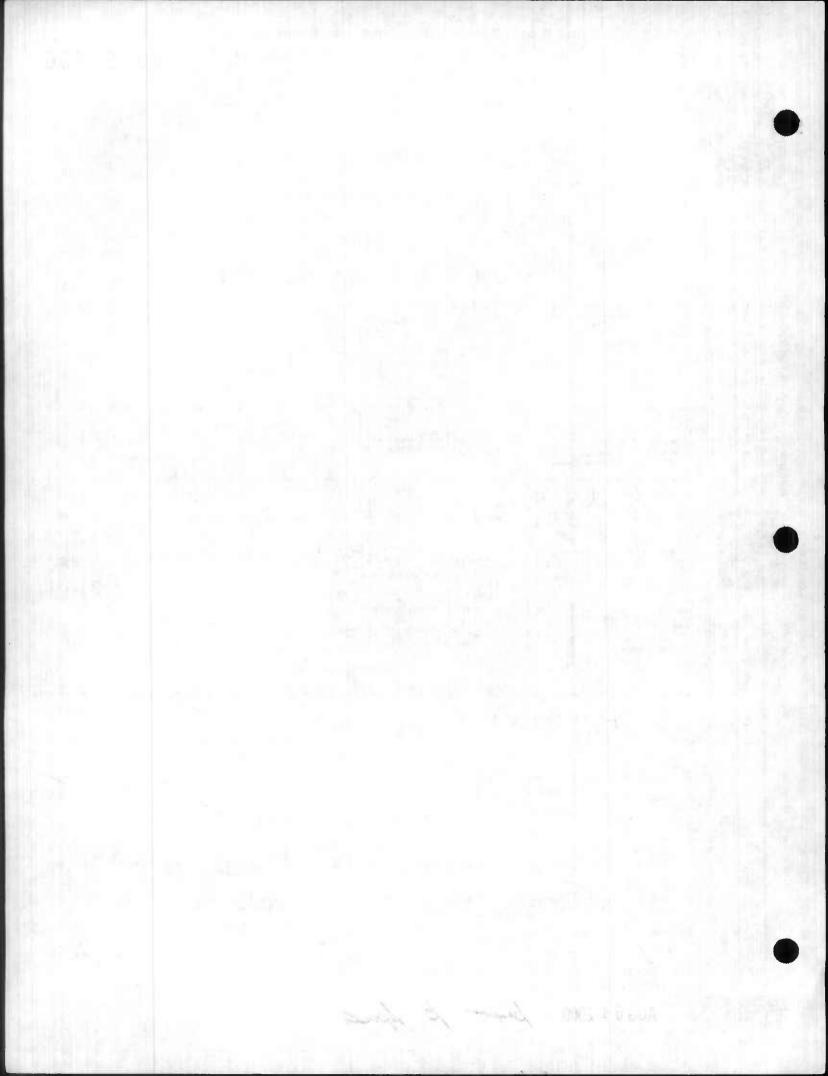
	Decedent's Name (First, Middle, L.	ast)		Certificate	or Death	2. Dete of De		3. Time of Death	
Physician /Medical	Mary Virginia Au	vil				August	Day 2.	OOO 4:45 PM	
Examiner	4a Fecility Name (If not institution, gr	ve street end number)	444	E IN	4b. City, Town, o	r Location of Deatl			
	13 Mulrany Ct.				Timoniu		Balt	cimore	
Funeral Director		- Die - M-	n yrs. last birtho	Months D	ear If Under 24 Hi ays Hours Mi	n. (Month, De	y, Year) 24,1936	Birthplace (State or Foreign Country) Marvland	
Р.	Usual Residence of Decedent		0.0						
ahow	10a. State 10b. County		Oc. City, Town o					10d. Inside City Limits 1 ☐ Yes 27 No	
the Meryle	Maryland Baltimo	ore	Timon						
with the Me to 728-1 a	10e. Street and Number			10f. Zip Co		100	10g. Citizen of V	vhat Country?	
death with the Meryland ms 23s or 28s-f show mast be notified at meral Director	13 Mulrany Ct.	AD Man Danidad For		2109		(Canaity Van as Na	United	States - American Indian,	
020 urs efter al', or he	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ar in 0,5.		of Hispanic Origin? Cuben, Mexican, Pue No Specify:	erto Rican, etc.)		k, White, etc. White	
72 hours natural;	15. Decedent's E (Specify only highest go		16a. D	ecedent's Usual O	ccupation one during most of w	orkina	16b. Kind of Bu	siness/Industry	
I 21215-0 led within 72 ho tygiene. The Medical it, the Medical it, the Medical it, the Medical it.	Elementery/Secondery (0-12)	College (1-4or 5+)	1	fe. DO NOT use n	etired)				
filed will Hygien, the ther the		2	te	acher	education 18. Mother's Neme (First, Middle, Maiden Sumeme)				
land le fill b	17. Fether's Name (First, Middle, Las							θ)	
should be filed of Mental Hyg marked other matter event,				4.11.		et McGra		Out. 7: 0-41	
2000	19e. Interment's Name/Relationship				reet end Number or				
other tr	Robert L. Auvil/1			Mulrany isposition (Name of		onium, M		City or Town, State	
	1 N Buriel 2 □ Cremetion 3	Removal from State	cemetery,	cremetory or other	plece)				
It Per rame of the second of t	4 Donation 5 Other (Spec		ulaney	Valley Me	m Gardens	8/4/00	Timoniu	m, Maryland	
Baltirr pemit. Pa Departmen important: eny Inlury ence.	21. Signature of Funeral Service Lice	LA III		22. Name and A	65	00 York I	Funeral Home, In		
	Game D. 1000	chell			Ba	ltimore.	MD 212		
	23a Pant. Enter the disease, or cor book, or heart tailure. List only	nplications that caused the one cause on each line.	e deeth. Do no	enter the mode of	dying, such as card	iac or respiratory e	rrest,	Approximate Interval Between Onset end Death	
Physician						-			
/ /Medical Examiner	Immediete Cause (Final disease or condition resulting in deeth)	. Mela	stal	u b	reart	Caro	inan	a 6 year	
<u></u>	12571	Du	e to (or as a co	nsequence of):					
nsit nsit		b							
68760, ficate be executed physician and ts the bunal-transit edical Examinel	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a co	nsequence ot):					
68760, ifficate be exa g physician as the burial-		C	e to (or as a cor	seamence of).					
fficate g phys as the		50	e to (or as a cor	isequence or).					
X ce ce		d							
death death of for u	Part II. Other significant conditions	contributing to death but r	not resulting in t	ne underlying caus	e given in Part I	23b. Did	tobacco usa cor	ntributs to the cause of death?	
P.O. that the de by the detached						10	Yes 2□ No	3 Probably 4 Unknown	
= 20				F 11-11					
Records, te lew requires to hes been signings 2 should be properly to mpleted by							an autopsy	24b. Were eutopsy findings eveileble prior to	
ew requires been so a should pleted						pend	integ:	completion of cause of death?	
						10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Vital Vital Certificate rector, per Pe Co	25. Was case referred to medical				26. Place of D	eath (Check only			
of Vita Physicien: this certific ral director,	1 Yas 2 No	Hospital:	2 ER/Outp	atient 3 DOA	Other	Home 52 Resi		er (Specify)	
Physical distribution of T. T.		28e. Dete of Injury	28b. Tir	ne ot 28c.	Injury at Work?	1	how injury occur		
Attending F r death. ector: After by the funar	1/SNatural 5 Pending 2 Accident Investigetic	(Month, Dey Y	ear) Inj	M	1 ☐ Yes 2 ☐ No				
Division of Vital To the Hopptal or Attanding Physicien: The within 24 hours after death. To the Purent Director: After this certificate completely filed in by the funaral director, pe Medical Certification: To Be Co	3 Suicide 6 Could not determined		- At home, farn Specify)	n, street, factory, of	fice	28t. Location (City or To	Street end Numb wn, Stete)	er or Rurel Route Number,	
Doubtal of thousal Dry (1864) in the Cal Cel									
ne Hosp n 24 hos Ne Fune pletely fe	29a. Certifier	hysician: To the best of n miner: On the basis of ex and manner stated	amination and/	death occurred et to or investigation, in	ne time, dete and pla my opinion, deeth oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	and due to the cause(s)	
To the H within 24 To the F complete		1 1	-	29c. Li	cense number		29d. Date signe	d (Month, Dey, Year)	
F 3 F 8	1	m Llah	4		0203	96	anon	st3, 2000	
	- Con	completed source of d	h (Hom one) C	ma Print			8	- 31 -00	
/	20 Name and address of server un-	CAUTIONNIOU CAUSA OT CAST	n (118111 238) (1	(סק, רווות)					
6	30. Name end address of person who Davis M. Hahn			ren Blad	Baltimor	e Marvil	and		
Seale	Davis M. Hahn	M.D. 5601 I	Loch Ray	ven Blvd.	Baltimor	e, Maryla	and		
State Registrar	1	M.D. 5601 I	Loch Ray	en Blvd.	Baltimor	e, Maryla	and		



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State of Maryland / Department of Health and Mental Hygiene 00 24666

				Certificat	e of	Death			Reg. No.		24000
Physician	1. Decedent's Name (First, Middle,	Last)		***				2. Deta of De Month	eth Dey	Yeer	3. Time of Death
/Medical	Helen Louise Bowie					41 Oh T.		August	01,	2000	6:00 P.M.
Examiner	4e Fecility Name (If not institution, 717 Milldam Road					TOW	son	ocation of Death		Baltim	ore Co.
Funeral Director	220-46-4417	6. Sex 1□ M 2\(\(\Delta\) F	Age (In yrs. last bir 84	Yrs. If Under Months	Deys	Hours	Min.	8. Date of Bird (Month, De May 27,	1916	9. Birth Col Hager	npleca (Steta or Fore intry) Stown, Mary]
-f ahow	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltir	nore Co.	10c. City, Town								10d. Inside City Lim
a or 28a-f a at be notified i Director	10e. Street and Number 717 Milldam Road			10f. Zip	Code 2128	36				of What Cou	of America
al; or items 23s or 28s-f show Examiner must be notified at by Funeral Director	11. Maritel Stetus 1 Never Merried 2XXMerrie 3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1	ŽNo	13. Was Decelif Yas, spe		dispanic Orlean, Mexican Specify:	gin? (Sp , Puerto	ecify Yas or No Rican, etc.)	y Yas or No- can, etc.) 14. Race - American Indien Black, White, etc. Specify: White		
natur mical	15. Decedent's (Specify only highest	grade completed)	ation completed) College (1-4or 5+) 16a. Decedent's Usual O (Give kind of work of life. DO NOT use in			durina most	of work	ing	16b. Kind of Business/Industry		
	12 Elementery/Secondary (0-12) 17. Father's Neme (First, Middla, L	5+)	Dieti	cian	18 Mothe	r's Name	e (First, Middle,		Hospital	1	
arked out	Harry Wesley Kaylor							Eakle	Wolder Od	, rollie,	
ā <u>•</u> ē	19e. tnforment's Neme/Reletionsh Dr. Harry Clay Bowie			. Mailing Address L7 Milldam				al Route Numbe Maryland	21286	wn, State, Zi	ip Code)
Department of Health Important: If Itam 27 any Injury or other tronger.	20a. Method of Disposition 1 🗓 Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (Sp.	3 □Ramovel from Stat	20b. Piece of cameter	Disposition (New by, cremetory or call Ridge Ceme	ne of ther ple		1	Dete 3/05/2000	20c. Locati	imore, N	Town, Stete Maryland
Important: If it any injury or or or once.	21. Signature of Funeral Service L	bensee	1	22. Neme er	d Addre	ss of Fecilit		k Towson O York Ro			
ysician	23a. Pert1 Enter the diseese, pr shock, or heart failure. List of	only the cause on each	od the deeth. Do i	not enter the mod	e of dyir	ng, such es	cardiac	or respiretory e	rrest,		Approximete Intervel Between Onsat end Death
Medical aminer	Immediate Causa (Final disease or condition resulting in deeth)	. (Due to (or as e.	obs-	tuc	tre	10	ng d	15ens	٠	15 yeu
attending physician and for use as the burial-trensit clan/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		espiral	consequence of):	Fui	lux	- Re	tion			2 week
ys the	Pert tl. Other significant condition	1.		the undarlying o	ause giv	ven in Pert I					to the cause of de
b od	- Htb.	thyworli	5-7					100	2168 2□1	10 3 Pr	obably 4 Unk
ate has been signed to pege 2 should be det								perfo	an eutopsy rmed?	8	Were autopsy finding available prior to completion of cause of death?
certificate rector, pe	25. Wes case referred to medical					26. Pleca	of Deet	h (Check only	/	0	Yes 2 No
T T	exeminar? 1 Yes 27. Mennus Death 1 Natural 5 Pending 2 Accident investige		jury 28b. 1	itpatient 3 DC	8c. Injui Woi	4LINU		ome 5 esi 28d. Describe			cify)
al Director: After the din by the funeral Certification:	3 Suicide 6 Could no determine	, offica			28f. Location (City or To	Street end N wn, Stete)	umber or Ru	iral Routa Number,			
To the Funeral Di completely filled in	29a. Certifier 1 Certifying (Check only one)	Physician: To the best taminer: On the basis and menner	of examinetion en	, deeth occurred d/or investigation	at the tir , in my c	me, dete en opinion, dea	d plece, th occur	end due to the red et the time,	ceuse(s) end dete end ple	d menner es ica, and due	stated. to the cause(s)
Toth	29b. Signetura and time contil			29	D	sa number	95		29d. Dete s	gned (Month	1, Dey, Year)
5	30. Name and eddress of person w		daeth (Item 23e)	(Type, Print)	alv	ert	5	Belf	0 2	81611	
State	31. Dete filed (Month, Day, Year) AUG 0 4 200		trer's Signeture	1-	de.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** DRUGTTA 7:350 BESS 8. 4b. City, Town, or Location of Death 25 2000 · /Medical 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Home Nursing Mmer BALHNULE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign Country) 6 Sex 1□M 2 TF Months 577-20-1153 5.0 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits BALLMORE CATUNSVILLE 1 Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CEONR CIRCLE 21228 U513 2026 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes No Specify: λq Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) FEDERAL GOVERNMEN SUPERVISOR UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be WILSON WOODTUW 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BARBARD Eaton Castusville, Marylons DRIVE TROKE 2026 (EMR (20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Buriel 2 Cremation 3 Removal from State 7/29/2000 HARMONY HemorIPL Book LANDOVER, Many long 4 □ Donetion 5 □ Other (Specify) 22. Name end Addrass of Facility CAATH m - Hmris Foresal Home 21. Signature of Funeral Service Ligensee 5240 PRISTEMENT MONDO Delay Drumo BALLARA, Minglows 2121 23a. Part / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final ona disease or condition resulting in deeth) Due to (or es e consequence of) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was cese referred to medicel Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examptor must be notified at

permit. Peges 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumatic avant

Physician /Medical

Examiner

physician end s the buriel-tran

80 Ö

been signed by the should be detached

page 2

director.

funeral

certificate

After

efter death. Director: Aft

24 hours e Funeral I Hospital

Toth

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pue

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

Records,

Division of Vital Attending Physician:

> 31. Date filed (Month, Dey, Yeer) AUG 0 4

DK. DEHANE

29b. Signature end to of certifier

32. Registrar's Signeture

29c. License number

17350

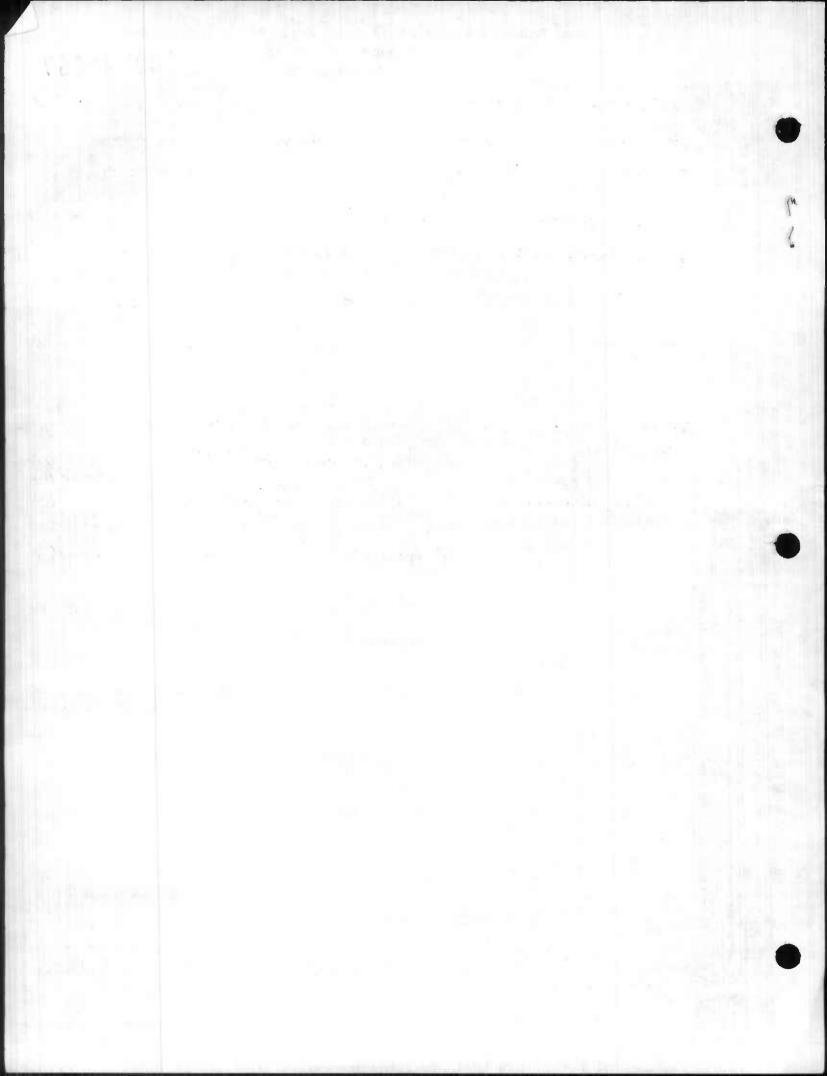
Wilkens

29d. Date signed (Month, Day, Year)

2000

Smite 302

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1. DECEDENT'S NAME (First, Middle, Last)	BROA	DU	2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
		(In yrs. last birthday) IF U	NDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIR	THPLACE (State or Foreign
	719-09-2177 1200205	87 YRS. MONT	THE DAYS HOURS MIN.	July 11, 1	9/3/	CArolina
OR	90. FACILITY NAME (If not institution, give street and number) 1718 E. 28 & Street	9b.	BAL HIMURO		9c. COUNTY OF	/
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY
	Mary AD W/A	BA	HIMORE			1 TES 2 NO
FUNERAL	1718 E. 28 H STREE	+	2/2/8		77	what country?
B	11. MARITAL STATUS 1 Never Merried 2 Merried Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico 1 YES 2 NO Specifi	n, Puerto Ricen, etc.)	Ble	CE - American Indian, ack, White, atc.
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUA (Give kind of work of	fone during most of working	16b. KIND OF BUS		
COMPLETED	Elementery/Secondery (0-12) Strander (0-12) College (1-4 or 5+)	LABORC		PRIVA	4/10	ustry
BE CO	17. FATHER'S NAME (First, Middle, Last) ALEX BROADY		18. MOTHER'S NA	ME (First, Middle, Maiden	Surneme)	
TOB	OARDUN BRAUGHT / NEC	E 17/8 E	RESS (Street and Number or Rural 28 H 3 KE.		11	31218 G Mary fors
		Ob. PLACE AND DATE OF DIS			CATION — City or	Town, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LATENSEE	wig kar	22. NAME AND ADDRESS OF PA			
	Dervy James			nd 2121		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	0.0	cinoma (a	Edenoca.)	interval Between Onaet and Death Thurty Lay
EDICAL C	PART II. Other significant conditions contributing to death	but not resulting in th	e underlying cause given in	Part i. 24a. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES [□ NO □ UNCERTAI	N D		1 YES 2 ND
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH (C				
14SI	1 ☐ YES 2 ☐ 1 ☐ Inpatient 2 ☐ ER/OL 27. MANNER OF DEATH 28s. DATE DF INJUR	stpatient 3 DOA 4 D	Nursing Home 5 Residence		Ulimi Couling	
ВУ Р	1 Natural 5 Pending (Month, Day, Year, 2 Accident Investigation	INJURY	WORK? 1 YES 2 NO	28d. DESCRIBE HDW I	NJORY OCCURED	
		RY — At home, term, street pecify)	, fectory, office	28t. LOCATION (Street of City or Town, State)	and Number or Run	il Route Number,
COMPLETED	29e. CERTIFIER (Check only of the best of my known of the control of the best of my known of the best of the best of exeminating the control of the best of exeminating the control of the best of exeminating the control of the best of exeminating the control of the best of the best of exeminating the control of the best of the be					e(s) end manner ee statud.
BEC	200. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU	MBER	29d. DATE SIGN	ED (Month, Day, Year)
10	38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	ATH (ITEM 27) (Type, Print	D212	42	Augu	N 1,2000
	4924 Clampbell Blvd	Suite 200	White me	rish, Ma	8 210	36,
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIC		oaks	,		

DHMH-16 Rev 1/89

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death July 26, ^{Day} 2000 **Physician** Corinne Ann Branham 8:30PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Mariner Nursing Home If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country)
 VA 8. Date of Birth (Month, Day, Year) **Funeral** Days 10 M 2 F Months Hours 216-28-9798 71 14, 1929 Director Mar. Usual Residence of Decedent the Maryland 10a State 10c City Town or Location 10b County 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f ahow traumstic event, the Medical Examinar must be notified at NO 2 No Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A 3 Silverton Rd. Apt. 2A Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiena.
Important: If Nem 27 Is marked other than * nature once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Name (First, Middle, Lest) Be Minnie V. Johns James B. Branham 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 930 Rawley Ridge Rd. Front Royal, VA. 22630 Ronald E. Parks, son 20b. Place of Disposition (Name of commetery, cremetory or other place)
Glen Haven Memorial Park 7-29-00 20a. Method of Disposition 20c. Location - City or Town, State **PD**Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) /Medical Anoxic encephalopathy 7-10-00 Examiner Due to (or as a consequence of): Examine Myocardial Infarction 1 month attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. several years certificate be Diabetes Physician/Medical Due to (or as e consequence of): Congestive heart failure years ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? pinous 24a. Was an autopsy performed? Completed peed has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 1 ☐ Yes 2 ☑ No After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Netural or Attending 5 Pending investigation s after death. 1 Yes 2 No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 31 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ranis Karipineni 4000 Annapolis Rd. Baltimore, MD. 21227

State Registrar

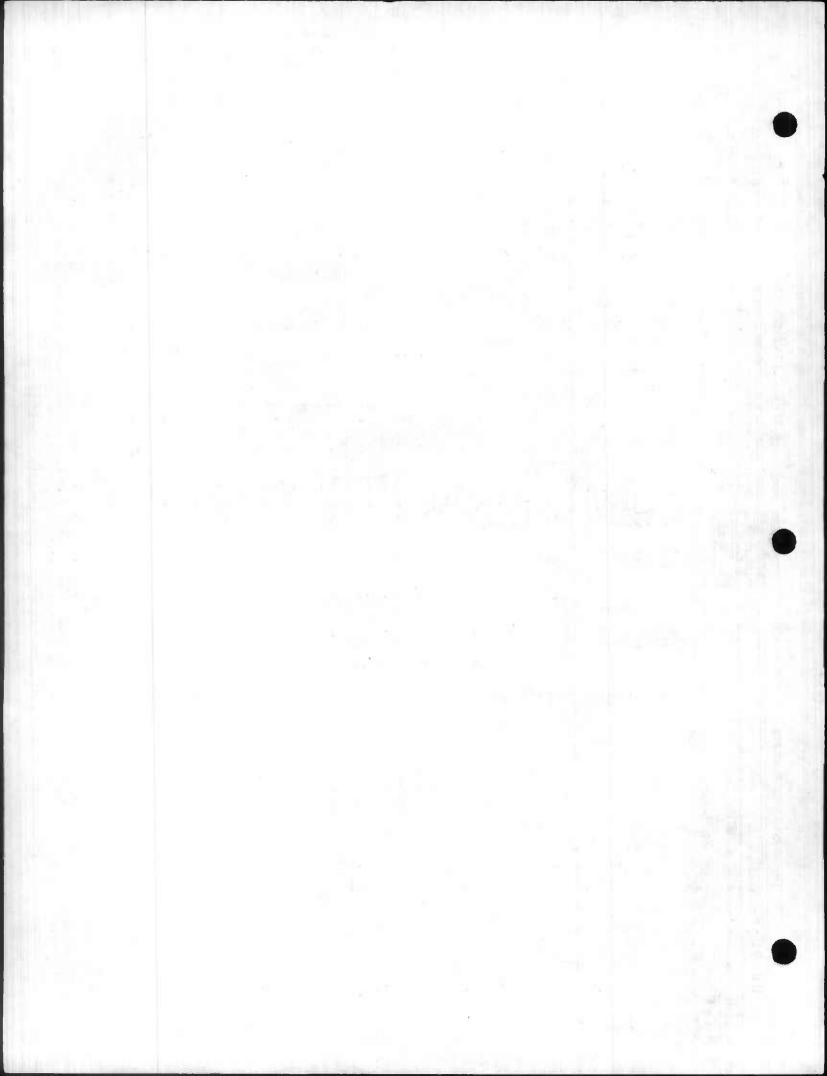
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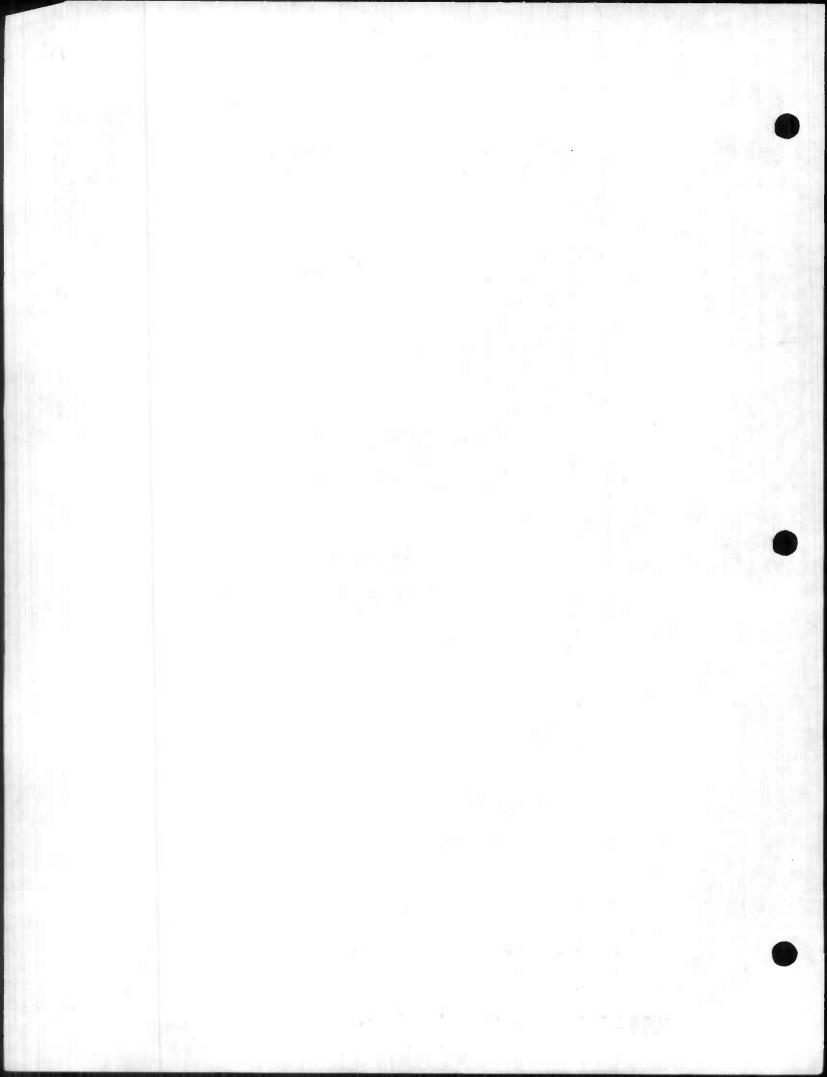
32. Registrar's Signature

24 March



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Physician /Medical Examiner	Decedent's Nama (First, Middla, Last, WTT.T.TAM F		State of Maryland / Department of Health an Certificate of Death							
	,	DWARD BAKER	ı			2. Data of De Month 7	Day	Yaar OO	3. Tima of Death	
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2 aho is me is me	19a. Informant's Name/Ralationship (Ty	pe, Print)			t and Number or Rui	ral Routa Numbe	er, City or Town,	State, Zip C	Coda)	
Health am 27 Sther t	ANNIE C. BAKER 20a. Mathod of Disposition	20b. P	laca of Dispos	sition (Nama of	LIA AVE.	BALTO	MD 2 20c. Location -		n, Stata	
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Department important any injury	21 Signalum a Funaral Sarvice License		KER 22	. Nama and Addra	ass of Facility ES	TEP BR	OS. FU	NERAI 21217	SERV.	
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The law ate has be page 2 s						10	Yas 2 No	10	Yes 2□ No	
Physician: The rail director, page To Be Co	25. Was casa rafarred to medical axaminar?	lospital:	_	Ot	26. Placa of Dea					
Physic rithis con and dire	1 Yas 2 No 27. Manner of Death	28a. Data of Injury	ER/Outpatien 28b. Tima of	t 3 DOA 28c. Inju	4 LI Nursing H		dance 6 □Oth how injury occur		200	
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within To the compl	29b. Signatura and titla of certifiar	sa number	29d. Data signed (Month, Day, Ye		ay, Year)					
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N	30. Nama and addrass of person who co		Bult	Print)	21201					

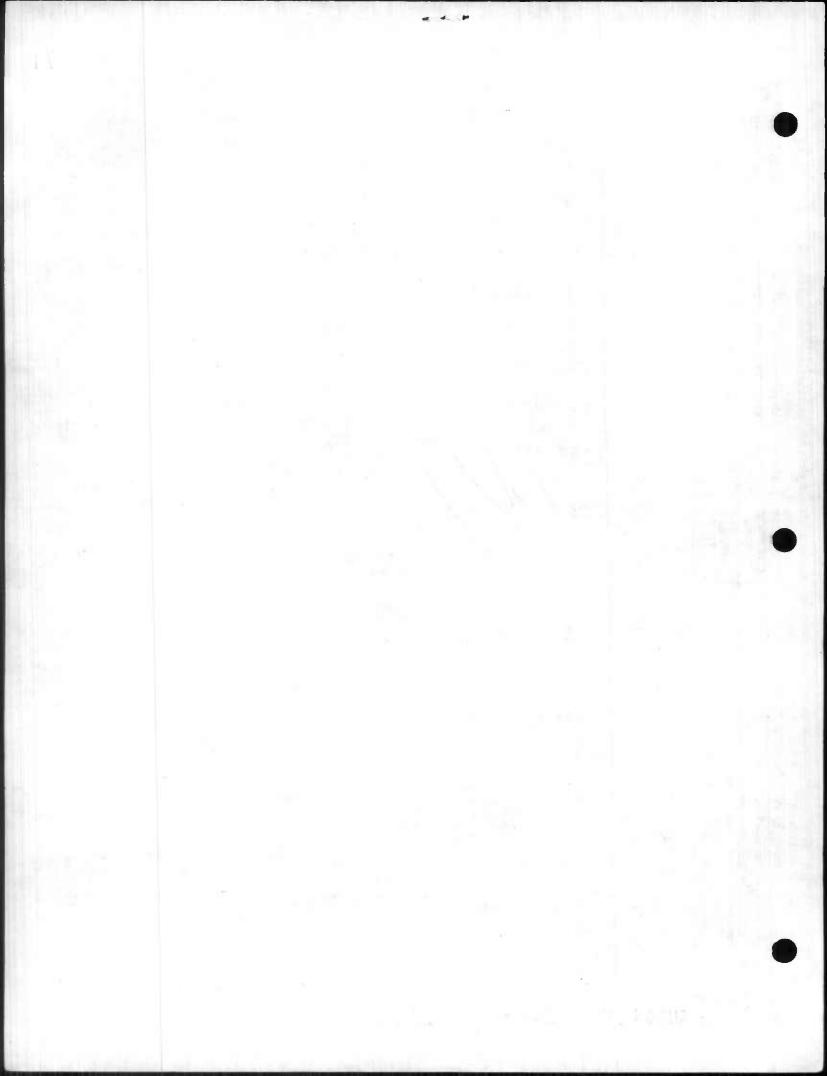


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State of Maryland / Department of Health and Mental Hygiene

24671

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dev Month **Physician** 7/31/2000 ERNEST R. BANKS 8:15 P /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICKEY BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 13 M 20 F 87 217 05 3629 Director MD Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No MD. Director BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3110 LEEDS STREET 21229 USA Funeral 14. Race - American Indian, Black, White, etc. AFRO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 These 2 No 10/43
If Yes, Give 11. Meritel Status # Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2∰ No Specify: Specify:AMERICAN à Year or Dates: 4/46 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CITY OF BALTO. Elementery/Secondery (0-12) College (1-4or 5+) LABORER PARKS 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be If Item 27 is merked RACHEL WATERS JAMES BANKS 19a. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) FARMER BERNICE 3110 LEEDS ST. BALTO. MD. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from Sales 4 Donetion 5 Other (Specify) WESTERN STAR 8/4/2000 CATONSVILLE, MD. 21: Signature of Pureral Service Licer 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 uain 23a. Part1. Entar the disease of complications the results. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical BEAIN TUMOR SWEEKS Examiner Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 an/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown PROSIDIC CINCER þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 175 Pice 1 Yes 2 No this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 W Neturel 5 Pending i or Attendin after death. Director: Aft 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital
 24 hours a
 Funeral C 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. To the Vithin 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature DO 6933 Abbu MD. and address of person who completed cause of death (Item 23e) (Typa, Print) MAR GIBBON MD 300 ADMORY PLACE SUITE 39 BALTOMORE MD 21201 31. Date filed (Month, Dey, Year) 32. Registrer's Şigneture AUG 0 4 2000 Registrar DHMH 16 Ray 6/95

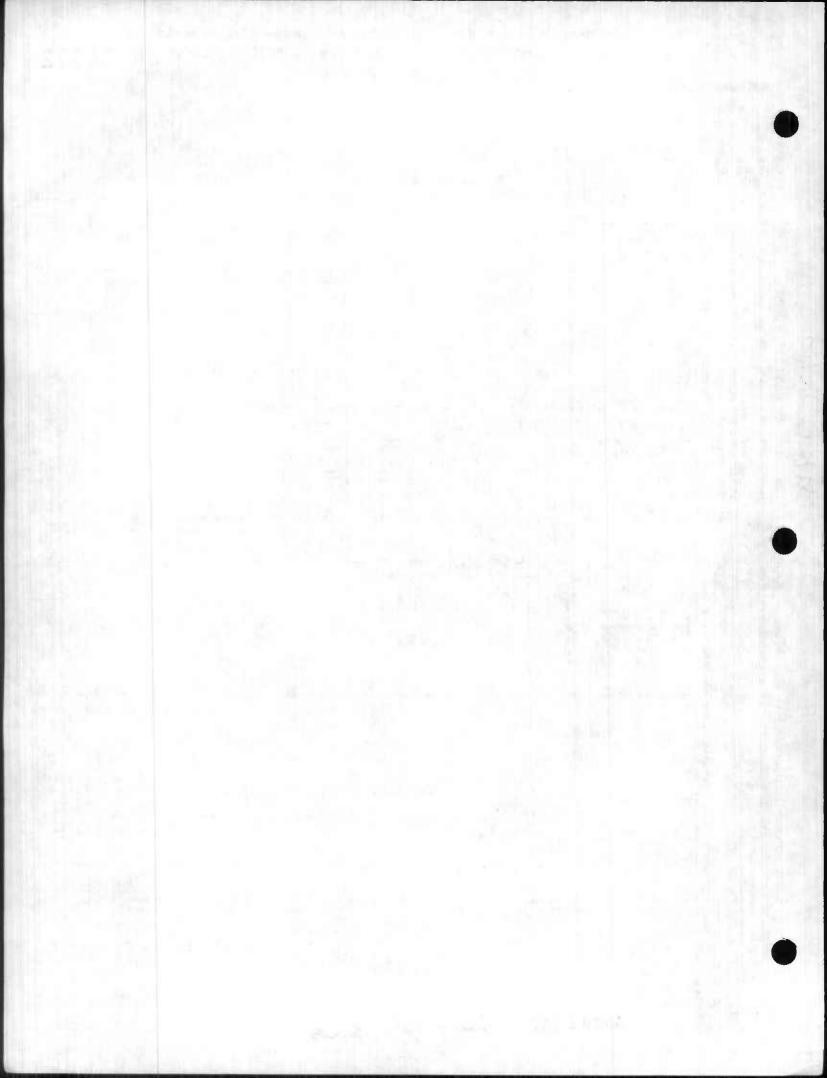


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State of Maryland / Department of Health and Mental Hygiene 00 24672

Physician Medical Examiner			
Julia Clayton Baker August	Day Yeer 3. Time of Death		
All City Town of Location of Deeth	2,2000 6:35pm		
EACHINIO	4c. County of Death		
Greater Baltimore Medical Center Towson	Baltimore		
5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Deta of Birth			
Director 576-36-7744 1 Month, Day, 1 November	16.1916 Texas		
Usuel Rasidence of Decedant			
10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits		
Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10	1 ☐ Yas 2 X No		
Plary Land Baltimore Luther VIIIe 10e. Street and Number 10f. Zip Code 10	g. Citizan of Whet Country?		
407 Brightwood Club Dr. 21093	United States		
11 Marital Status 12, Was Decedent Evar in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Amarican Indian,		
Armed Forcas? Armed Forcas? If Yes, specify Cuben, Maxican, Puèrto Rican, etc.) Armed Forcas? If Yes, specify Cuben, Maxican, Puèrto Rican, etc.) Armed Forcas? If Yes, specify Cuben, Maxican, Puèrto Rican, etc.)	Black, Whita, atc.		
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17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Mid			
17. Fathar's Name (First, Middle, Last) William Lockhart Clayton 18. Mothar's Name (First, Middle, Maling Address (Streat and Number or Rural Route Number, Print) 19a. Informant's Name/Relationship (Type, Print) Son- 19b. Mailing Address (Streat and Number or Rural Route Number, Print)	lughan		
John Brentnall Powell, Jr./1in-One Charles Center, 16th Floor	Baltimore, MD 21201		
20b. Place of Disposition (Nama of cemetary, cramatory or other place)	Oc. Location - City or Town, State		
John Brentnall Powell, Jr./in- One Charles Center, 16th Floor 20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 3 Data 2 20c. Place of Disposition (Nama of cemetary, cramatory or other place) 3 Data 2 4 Donatlon 5 Other (Specify) Greenmount Crematory 8/5/00 21. Signature of Fuparal Sarvice Licensee 22. Nama end Addrass of Facilit Mitchell-Wie 6500 York Rd Real times and Addrass of Facilit Mitchell Real times and Real	Baltimore, Maryland		
21. Signature of Funaral Sarvice Licensee 22. Nama end Addrass of Facility Mitchell—Wie			
21. Signature of Funeral Sarvice Licensee 22. Nama end Addrass of Facility 1 CCnell—wile 6500 York Rd			
Date inote, I.			
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Medical Immediata Causa (Final diseasa or condition rasulting in death) a. Cerebruvas Cular Accident	Week		
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B & E b Atrial fibrillation	1 Week		
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Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Diseasa or injury C.			
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of):			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24673 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day / Month **Physician** 49 /Medical 4c. County of Death ard 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Floor Ve 24 Hrs. If Under 1 Yea 5. Social Security Number 8. Data of Birth (Month, Day 9. Birthplace (State or Foreign Qountry) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours -56-721 10 M 20 F Director Usual Rasidence of Decedant the Maryland 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be nothing at 1 Yes 2 No Director larvland more 10f. Zip Code 10e. Street and Number 3rd 10g. Citizen of What Country? 8 Floor 82 or Nerns 23s tan JVP Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11 Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item blace. Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Giva Year or Dates: Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retined) 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) hanic 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be and Print (Brother 19a. Informant's Name/Ralationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21144 aw Ma. namb vern 20e. Mathod of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Othar (Specify) es of Funeral Service Licens 22. Name and Address of Facility Joseph Hon Ku uneral L. W. North IVE 10: Physician /Medical Immediate Causa (Final 1301 disaasa or condition rasulting in death) Examiner Examiner physician and s the burial-transit that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): attending F signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. CTRYOS 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes ANNo 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28d. Describe how injury occurred 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 5 Panding invastigation 1 Natural death. 1 Yes 2 No 2 Accidant 24 hours after deaf Funeral Director: 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö filled in Hospital 29a. Cartifier Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signeture end titla of 29d. Data signed (Month, Day, Year) 244944 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Column Street Daltimore mo 2/218

ORIGINAL

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32. Registrar's Signature

Wolke

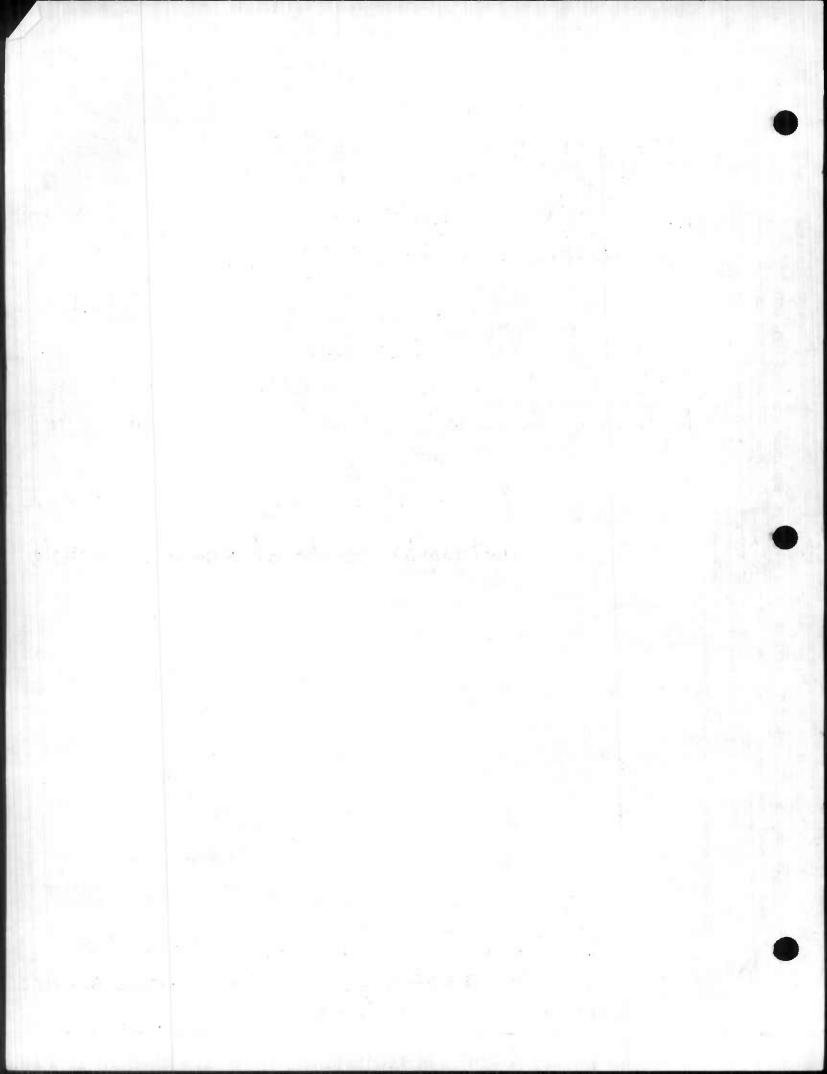
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31. Date filed (Month, Day, Year) AUG 0 4

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 24674

					Certifica	ate of	Death		Reg	ı. No.		
		1. Decedent's Neme (First, Middle, La.	st)					2. Dete	of Deeth		vic.	3. Time of Death
Physi /Me/		LEONARI		J.		CHASI	EN	JULY	31,	2000	Yeer	10:00 AM
/Med Exam		4e Facility Neme (If not institution, giv	a street end number)				4b. City, Town	n, or Location of	Death	4c. County of	of Death	
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Funera	al	5. Sociel Security Number 6. S		(In yrs. lest b	JII II TURY	der 1 Yaar	If Undar 24	Hrs. 8. Date	of Birth			leca (Stete or Foreign try)
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the the	Director	10a. Street and Number			10f.	Zip Coda			100	. Citizen of W	hat Cour	try?
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d within 72 hours at giene. or than "natural", or me Wedral Error	by	3 Widowed 4 Divorced	If Yes, Give Year or Datas:		1 L Yes	2 X No	Specify:			Specify:		WHITE
n 72 hours natural.	Completed	15. Decedent's Ed		16	e. Decedent's U	suel Occu	pation	44/:-	16	b. Kind of Bus	siness/Inc	dustry
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and day	ou .	Michael	Druger		8900	REIS	TERSTOW	N ROAD	- PI		OS., INC., MD 21208	
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State of Maryland / Department of Health and Mental Hygiene 0 24675

			Certific	cate of De	eath		Reg. No.	6m "Y	010
Physician /Medical	1. Decedent's Name (First, Middle, Last)	55				2. Date of Dec	P5 1	000	3. Time of Death H: 19 F.M.
Examiner	4a Facility Name (If not institution, give s VAMHES 5. Social Security Number 6. Sex	LTIMORE D	VISION		City, Town, or Lo BALT (Under 24 Hrs.)	MORE			ne (State or Foveign
Funeral Director		M 2□F 51	Yrs. Mon	iths Days	Hours Min.	8. Date of Birt (Month, Da)			ce (State or Foreign y) 1D
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ufter death with the Mainter death with the Mainter as 23e or 28e-f aiding maint be notified by the contract of the contract o	10e. Street and Number 4901 York Road		2	Zip Code			10g. Citizen of W		
002 urs by	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U, Armed Forces? 1 Yes 2 No 17 Yes, Give Year or Dates:		specify Cuban, I	anic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Specify:	- American c, White, etc	c.
T 0 1 2 3	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's (Give kind of life, DO NO	Usual Occupation If work done duri OT use retired)	on ing most of worki	ng	16b. Kind of Bus		
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Aaryla 2 should and Men la marke eumetic	19a. Informant's Name/Relationship (Typ.	oe, Print)	1	lress (Street and	Number or Rura	I Route Numbe	r, City or Town, S	State, Zip C	(ode) 21212
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altimore mit. Pages 1 partment of He portant: if Nen y Injury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	lace of Disposition emetery, crematory	or other place)	VA Chr	Dete	20c. Location - 0		n, State MD ings Mill
Dalti Departri Importa eny inju	21. Signature of Funeral Service License Rumad D		22. Nam	e and Address o	of Facility				21202
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.	HEMORR							Onset and Death
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T DE N	resulting in death) Last		as a consequence	Ot).				1	
· p · p	Part II. Other significant conditions cont	ributing to death but not resu	ilting in the underly	ing cause given i	in Part I.	23b. Did t	obacco use con	tribute to ti	he cause of death?
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2 2 8 P						24e. Wes perio	an autopsy med?	evail	e autopsy findings able prior to pletion of cause seth?
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Of Vital I Physician: The This centificate and director, pages.: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	SDIO 4-15-4 OF	Other	6. Place of Deeth				
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Division of standing P as after death. I Director: After to in by the funeration: Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fa		s 2 No	28f. Location (S City or Tow	itreet and Numbe n, State)	er or Flural F	Route Number,
Division To the Hospital or Attending within 24 hours after deeth. To the Funerel Director: Alte completely filled in by the fun Medical Certificatio	29a. Certifler 1 Certifying Physics (Check only 2 Medical Exerging only)	To the Kest of my know	vledge, death occur ion and/or investiga	rred at the time, ation, in my opini	date end plece, e	and due to the ded at the time, o	ause(s) and man	nner as stat nd due to th	ed. he cause(s)
To the comple	29b. Signature and title of cooling			29c. License nu	umber		29d. Date signed	(Month, Da	sy, Year)
	211,4	N		P124	1		July 25	,200	00
R,	30. Name and address of person who con	molecular cause of death (Item	23a) (Type, Print)	J Ball	sinor !	St, E	Saltino	ZM.	D 21201
State	31. Date filed (40nt), Day, Year) AUG 0 4 2000	32 Registrar's Signat	ure 4			/			

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amend item 4a per phys. G786 8/23/00 State of Maryland / Department of Health and Mental Hygiene amend item 10e per fh G786 8/4/00 yg Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Dete of Death Month **Physician** Buchman Doyle 31, 2000 8:30 AM July /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner 36 Anderson Ridge Road Anderson Ridge Road Catonsville Baltimore If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Deta of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) **Funeral** 1□M 200 F 09/29/1910 229-64-3270 89 Ohio Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show 1 Yes 2 No Directo Baltimore **CAtonsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 36 Anderson Ridge Road 230 36 Anderson Ridge RD 21228 USA Funeral or Rerrie 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 22No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) condary (0-12) Registered Nurse Johns Hopkins Hospital Department of Health and Mental My Introportant: If Health and Mental My Introportant: If Hean 27 is marked other any Injury or other two 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fredolin Leo Buchman Cecilia Martha Wurm 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 36 Anderson Ridge Rd Baltimore, MD 21228 Louise Doyle Dingle 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■Buriel 2 □ Cremetion 3 □ Removel from State 08/05 Lynchburg, VA Holy Cross Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funerel Servica Licensee Sterring Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, Md. 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximeta Interval Batween Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceusa. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last certificete be execut Box 68760, Physician/Medicai Due to (or es e consequence of) 88 ettending P.O. signed by the eld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown of Vital Records, þ 24b. Were eutopsy tindings 24a. Was en autopsy performed? Completed aveilable prior to completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No f or Attending Physician: after death. 25. Wes casa rafarrad to medical Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of Division 1 Natural 5 Pending investigation Injury 2 No 2 Accidant 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certified 7 run a 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 0 ichola 10 RTUIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2000 Registrar **DHMH 16 Rev 6/95**

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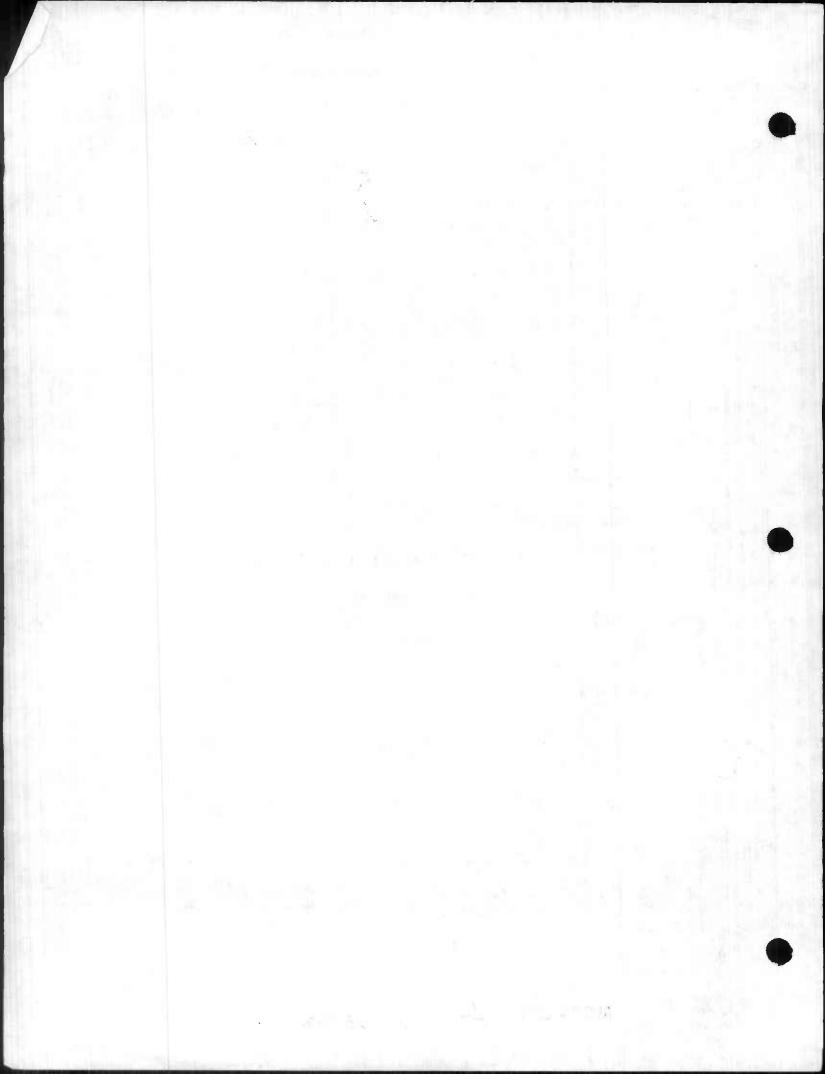
State of Maryland / Department of Health and Mental Hygiene 00 24677

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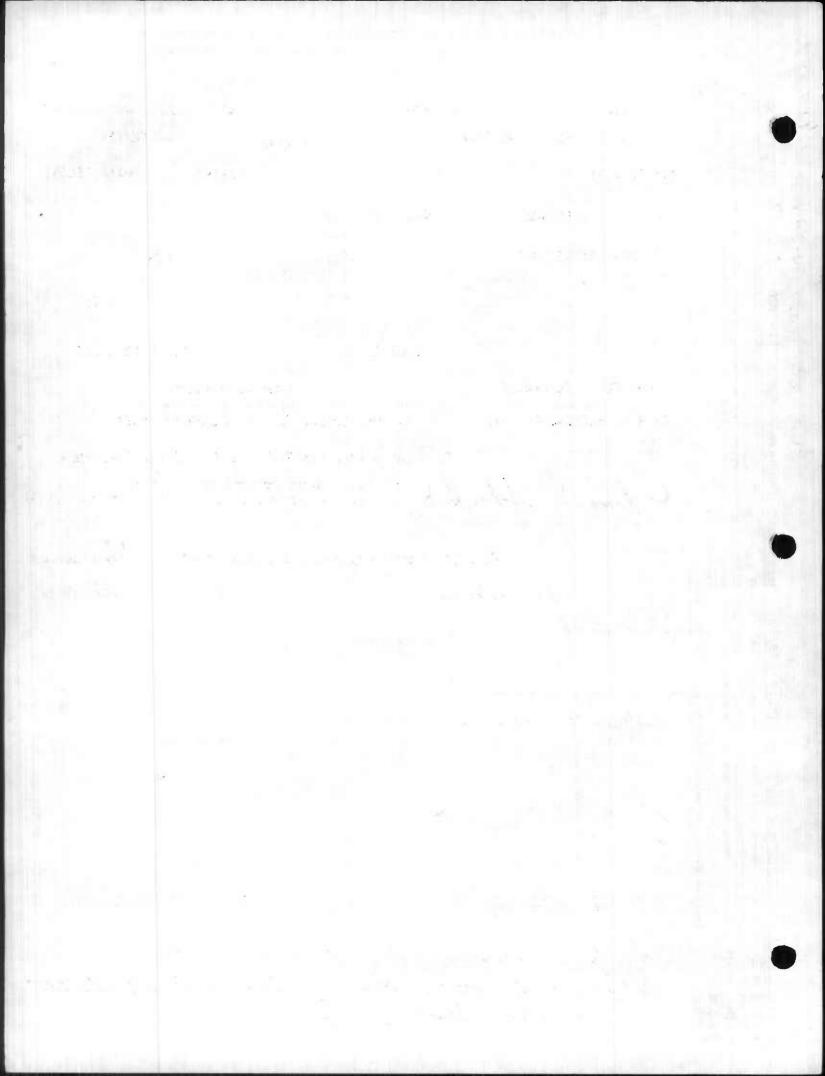
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Examiner Funeral Director	4a Facility Neme (If not institution, giva street and number) 113 POINT PLEASANT ROAD 5. Social Security Number 218-36-6770 6. Sex 1 M 2 □ F 7. Age (If	In yrs. last birthday) If Under 1 Year Months Deys	4b. City, Town, or Location of Dea GLEN BURNIE If Under 24 Hrs. Hours Min. B. Date of B (Month, D JAN a	ANNE ARUNDEL				
pus & s	Usuel Residence of Decedent 10a. Stete 10b. County 10	Oc. City, Town or Location		10d. Inside City Limits				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** FLEETWOOD ANIES 07 00 16:40 30 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 F Months Days Hours Min Yrs. 2/2/42 58 194-32-4598 PHILA, PENNA. Flectwood, Penes 194-32-4598 Director Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits DELAWARE PA DARBY TOWNSHIP 1 ☐ Yes 2 No ecto 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ä 101 WESTBRIDGE ROAD USA 19036 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

V\(\) Yes \(2 \) No
If Yes, Give
Year or Dates: \(61-65 \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian Biack, White, etc. 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: by WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) POSTAL CLERK U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middle, Last) HORACE J. FLEETWOOD ROSE M. FLANNERY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) LILA O. FLEETWOOD WIFE 101 WESTBRIDGE RD. GLENOLDEN, PA. 19036 f Health Ham 27 20e. Method of Disposition

1 Disposition 3 Removal from Stete 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20c. Location - City or Town, State SS. PETER & PAUL CEMETERY 8/3/00 MARPLE TWP. PENNA. 4 Donetion 5 DOther (Specify) 21. Signature of Poweral Service Licenses 22. Name and Address of Facility
David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. Listonly one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in daath) ACUTE MYOCARDIAL INFARCTION FIN MINIS Examiner Due to (or as a consequence of) Examiner SCUD EN YEARS attending physician and for usa as the burial-transit certificata be axecuted Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t MELLITUS Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Dey Year) uneral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No death. after death 6 Could not be datarmined 3 Suicide 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) Piace of Injury - At homa, farm, street, factory, office building, etc. (Specify) in by 4 T HomicIda ò 24 hours 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurred at the time, data and place, and dua to tha ceuse(s) end mannar as stated. Medical completaly 25 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. (Check only one) To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 07-31-00 30. Name end address of person who complated causa of daath (itam 23a) (Type, Print) SUCKU S. SUOW HILL MD. ING. OLZWORTH, UNROTHY 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 0 4 2000 > Registrar **DHMH 16 Rev 6/95**



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State of Maryland / Department of Health and Mental Hygiene 0 24680

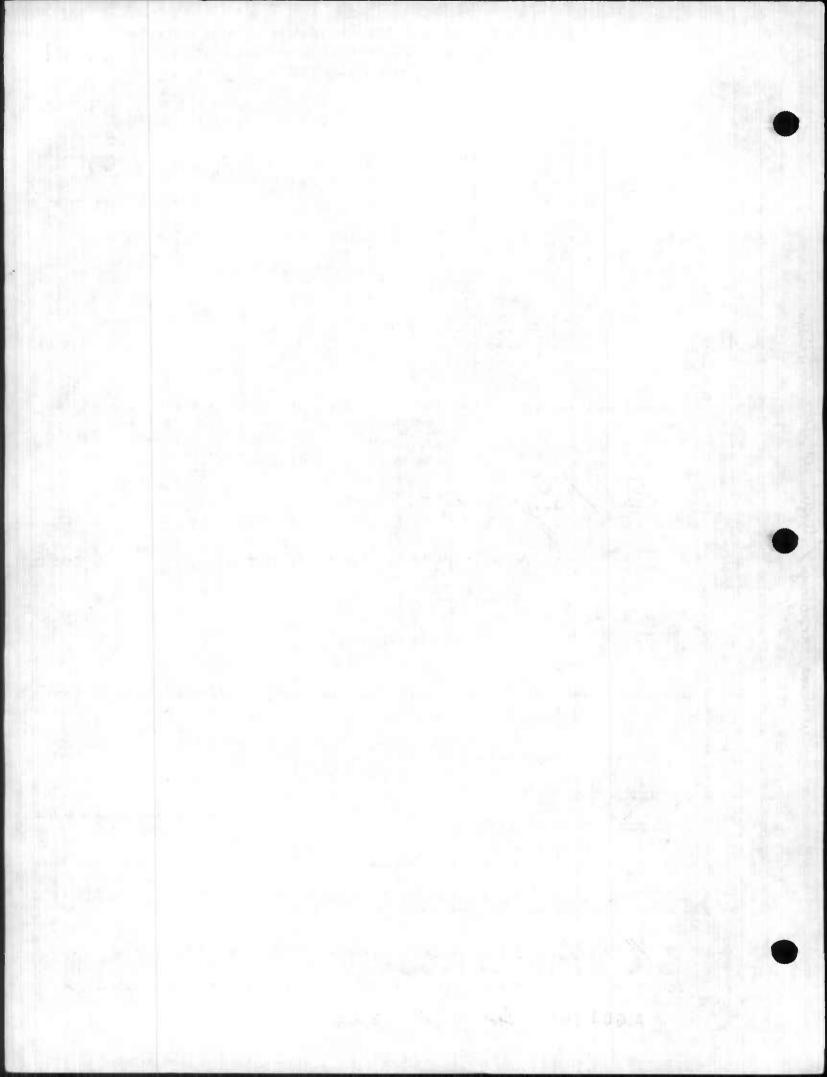
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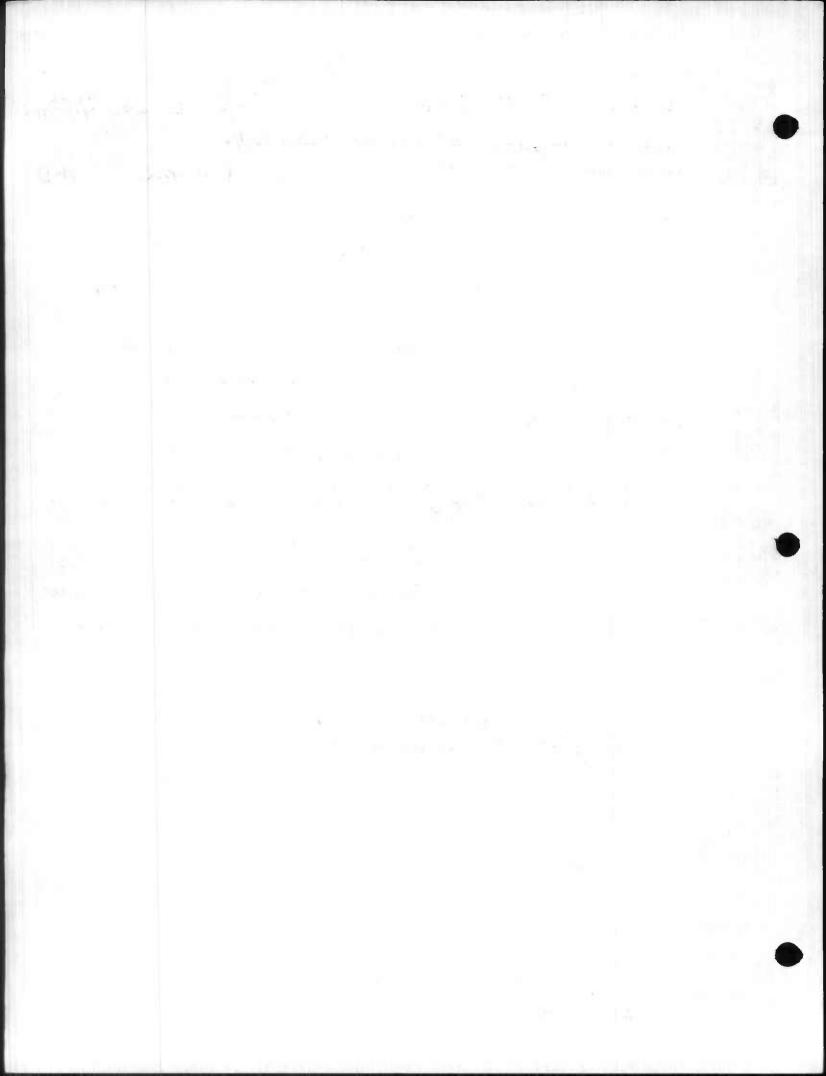
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*51	10a. State 10b. County		10c. City, T	own or Loc	ation				10d. Insida City Lin			
or 28a-f show	Maryland Baltimore		Tov	vson						30	1 Yas 2	
23a or 28a-f should be notified at	10e. Street and Number	7.8			10f. Zij	Coda				0g. Citizen of What Country?		
e 23a	543 Piccadilly Road			40.11	1	2120		>	U.S.,		ican Indian,	
edeal Essening must be notified et ed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1 ☑Yes 2 ☑ N If Yas, Giva Year or Dates:	ned Forcas? It Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Wh. XYes 2 □ No as, Giva 1,1,1,1, TT 1 □ Yas 2 ☑ No Specify: Specify:						lack, White			
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3 0	Elementery/Secondary (0-12)	4 College (1-4or 5-	+)		sign E				Δ.	AT & T		
CO	17. Father's Nama (First, Middle, Last)	Т		1003	orgii L	ingink		ma (First, Middla				
To Be	Alphonse	Gregory					Anna		Ritter			
other treumetic event, the	19a. Intormant's Name/Relationship (Type	pe, Print)		19b. Mailing	Addres	s (Street	and Number or R	ural Routa Numb	er, City or Tov	vn, Stata, Z	ip Code)	
other tr	Mary Gregory / Wife						oad Towsor					
م م م	20a. Method of Disposition 1 Durial 2 Cramation 3 R	emoval trom Stata	cam	e of Dispos afary, cram	atory or	thar pla	Gardens 8/	Date // /2000		ium, Maryland		
ulary v	4 Donation 5 Other (Specify)	1	Dulai								ylana	
eny injury or pace.	22. Nama and Addrass of Facility 1050 York Ro Ruck Towson Funeral Home, Inc. Towson, Md. 2 23a. Part 1. Enter the uneass or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart tellural attentions of the cause of the death.											
	23a. Part1. Enter the season or compli shock, or heart tellure state only of	ceuse on each lin	tha daath.	Do not anta	r the mo	de of dyi	ng, such as cardia	c or raspiratory a	irrast,	1	Approximate Interval Batwee Onsat and Dea	
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niner	disaesa or condition resulting in death) a. Non. hoogicing tymphomia										1 mont	
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burial al E	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):											
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hed for use a	Part II. Other significant conditions con	tributing to death bu	t not resultin	ng in the un	darlying	ausa gi	van in Part I.	23b. Did	tobacco uae	contribute	to the cause of d	
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should be det						7	V:YN	24a. Was	an autopsy	24b. V	Wara autopsy tind	
octor, page 2 should Be Completed								perf	ormed?		evailable prior to completion of cause of death?	
ege 2								10	Yas 2 No	1	I ☐ Yas 2 ☐ No	
director, page 2	25. Was casa reterred to medical axaminar?						26. Place of De	ath (Check only	ona)			
die G	1 ☐ Yes 2 No	1	nt 2 EF			JA		Homa 5 ☐ Ras			oin Hospi	
funera funera fon:	27. Mannar of Death 1 ANetural 5 Pending	28a. Data of Injury (Month, Day		3b. Tima of Injury	м	28c. Inju Wo	nyat ork?]Yas 2∐No	28d. Dascribe	how injury oci	curred		
	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicida detarmined	28a. Placa of Inju building, atc		a, tarm, stra				281. Location City or To	(Street and Nu wn, Stata)	m <i>ber</i> or Ru	ral Route Number	
etely fille dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete and place, end 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred and mannar statad.											
To the Funeral Director: completely filled in by the Medical Certifica	29b. Signatura and titla of certifier	1 4			29	c. Lican	sa number	1	29d Date sig	ned (Montl	h, Day, Year)	
1	I Anthony Piley us D25205 August 1, 2000											
	30. Nama and addrass of person while W. R. R. R.	CBMC	G 70			l ov	les St.	Balt	. mo	1 21	20%	
	31. Data tiled (Month, Day, Year)	32. Registra				1	3/				~ /	



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nysicia: Medica	al .	1. Decedent's Name (First, Middle,	Gallac	sher			2. Date of Month	Day 2	Year Year YYCX			
xamine neral ector	er	214-20-2449	tealth	Cato ge (In yrs. last I	birthday) If Und Months	er 1 Year If Ur	nder 24 Hrs. 8. Date of I (Month, or Location of De	ath 4c. Count Ball Birth Day, Year)	9. Birthplace (State or Foreig			
福田	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				10d. Inside City Limit			
notified	5	MD Baltime	ore	Lansd	owne				1 ☐ Yes 2 🗷 N			
tor ed ten	5	10e. Street and Number 329 Second Ave				ip Code 227		10g. Citizen of What Country? U.S.A.				
Examiner m	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces d 1 ☐ Yes 2 ☑ tf Yes, Give Year or Dates:	7		edent of Hispanic ecify Cuban, Med 2 ^M No Spe	c Origin? (Specify Yes or kican, Puerto Ricen, etc.) cify:	(Specify Yes or No- into Ricen, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
event, the Medical Exe	Be Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12) 8	Education grade completed) College (1-4or	54)	e. Decedent's Us (Give kind of w life. DO NOT Iomemake)	ork done during use retired)	most of working	16b. Kind of E	Business/Industry Home			
	o ge	17. Father's Name (First, Middle, L John Joseph Gra					lother's Name (First, Midd Margaret B.		me)			
other traumatic		19a. Informant's Name/Relationshi		15	9b. Mailing Addre 329 Seco	ss (Street end No	um <i>ber or Rural Route N</i> un Lansdowne ,	MD . 2122	n, Stete, Zip Code) 2.7			
ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donalon 5 ☐ Other (Spi		20b. Place cemer Meado	of Disposition (N tery, cremetory or owridge	eme of other place) iemorial	Park 8-7-00		- City or Town, State ey, MD			
any injury o		21. Signature of Wuneral Service L		M) O			acility al Home of 1		e, MD. 21227			
attanding physician end for use as the bunda-transit for use as the bunda-	edicai	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e	Due to (or as	a consequence of	Tuy	ner Kedy	ey	Onset and Death 3 class 1 Mary			
se detached	by Physicianum	Part II. Other algnificant condition Dialect	s contributing to death b	out not resulting	In the underlying	ceuse given in P		ld tobacco usa co	ontribute to the cause of death			
ga 2 should	Completed	Perip	heal	Vas	culos	Dur	of pe	es en eutopsy normed?	24b. Were autopsy findings aveilable prior to completion of cause of death?			
director, pa		25. Wes case referred to medical examiner?				26. F	Place of Death (Check onl		10165 2010			
P	2	1□ Yes @D/No		ent 2 ER/			Nursing Home 5 ☐ Re					
eur C	Cauons	27. Menner of Death C⊠Natural 5 ☐ Pending 2 ☐ Accidant Investiga 3 ☐ Suicide 6 ☐ Could no	t be	y Year)	Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	e how Injury occu	urred			
d n		4 Homicide determin	building, el	c. (Specify)	farm, street, facto		City or 1	Town, Stete)				
9		(Check only 2 Medical E	f examination e	end/or Investigetion	n, In my opinion,	death occurred at the tim	e, date end place	, end due to the cause(s)				
letaly filled	200	one)	and manner st									
completely filled in by the fo		one) 29b. Signature and title of certifier	manner st	2	2	D20	Ly Ly	29d. Date sign	ed (Month, Dey, Yeer)			

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dle, Las		Mary	Grove	2				2. Date of De Month		ву	Year	3. Time of Death	
			GIOVI	-	т.					st 2, 20		1:15 p.m.	
	street and numb 9501 Longvi					lb. City, Town,		cott City	Howard			oward	
6. Se	ex 7. □ M 2□√F	. Age (In yrs.	last birthday) 84 Yrs.	If Under Months	1 Yeer Days	If Under 24 I Hours N	Hrs. Jin.	8. Dete of Birth (Month, Pey, Year) November 29, 1915			9. Birthp Cour	Birthplece (State or Foreign Country) Maryland	
у		10c. Cit	y, Town or L	ocation							1	10d. Inside City Limits	
Н	loward				E	Ellicott City	V					1 ☐ Yes 2 ☐xNo	
)rivo				10f. Zip	Code	2104	42		10g. C	itizen of V		ntry? S.A.	
Orive	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es?	,S. 13.	Was Decede	ify Cube	ispenic Origin? en, Mexican, Pr	? (Sp	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	can Indian,	
	's Education 16a, Decedent's Usual O					one during most of working etired)				Kind of Bu		dustry ay School	
	2+	,			Sch	ool Teach	er						
av W	/illiam Eklof,	, Sr.				18. Mother's	Nem	e (First, Middle		n Sumem Strot			
ship (7	ype, Print)	Son	19b. Maili			end Number of	_				Stete, Zip	Code)	
	Removal from St		Place of Disponentery, cre Good	osition (Nam metory or of Shepher	her pled	metery	08	Date 3/05/2000	20c. l			own, State y, Maryland	
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or comp st only o	olications that cause on each	used the deat ch line.			of dyin	g, such es car		1			1	Approximate Interval Between Onset end Death	
	fleu		or as a conse		lik	meas	/	luct 6	206	suis			
	D.	Due to (c	er es a conse	quence of):		/							

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

disease or condition resulting in death)

1. Decedent's Neme (First, Mid

4a Fecility Name (If not instituti

212-28-3756 Usual Residence of Decedent

9501 Longview [

1 Never Married 2 Ma

3 Widowed 4 Divorce

19a. Informant's Name/Relation Mr. Donald C

20a. Method of Disposition 1 ☐ B¥rial 2 ☐ Cremation 4 Donation 5 Other

15. Decede (Specify only high Elementary/Secondary (0-12) 17. Father's Name (First, Middle

Gust

10b. Coun

5. Social Security Number

Maryland 10e. Street and Number

11. Marital Status

10a. State

Physician /Medical

Examiner

Funeral Director

filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Exercises must be notified at PARE.

To Be Completed by Funeral Director

Cleur Due to (or as a consequence of):	brual Quetadous
Due to (or es a consequence of):	
Due to (or as a consequence of):	
ng to death but not resulting in the underlying cause gi	iven in Pert I. 23b. Did tobacco uss contrit

Physician/Medical Examiner Part II. Other significant conditions contr to the causs of death? Hyle Blood Preum ? 1 Yss 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed?

		1 Tes 2 No 1 Tes 2 No									
25. Was case referred to medical	26. Place of Death (Check only one)										
exeminer?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☑ Residence 6 □Other (Specify)									
27. Menner of Death 1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigatio	on (Month, Day Year) Injury Work?	d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	281. Location (Street end Number or Rurel Route Number City or Town, Stete)									
29a. Certifier 1 Certifying Pt	hysician: To the best of my knowledge, deeth occurred at the time, date and place, and	I due to the ceuse(s) and manner as stated.									

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

alexander buyer

29c. License number D008780

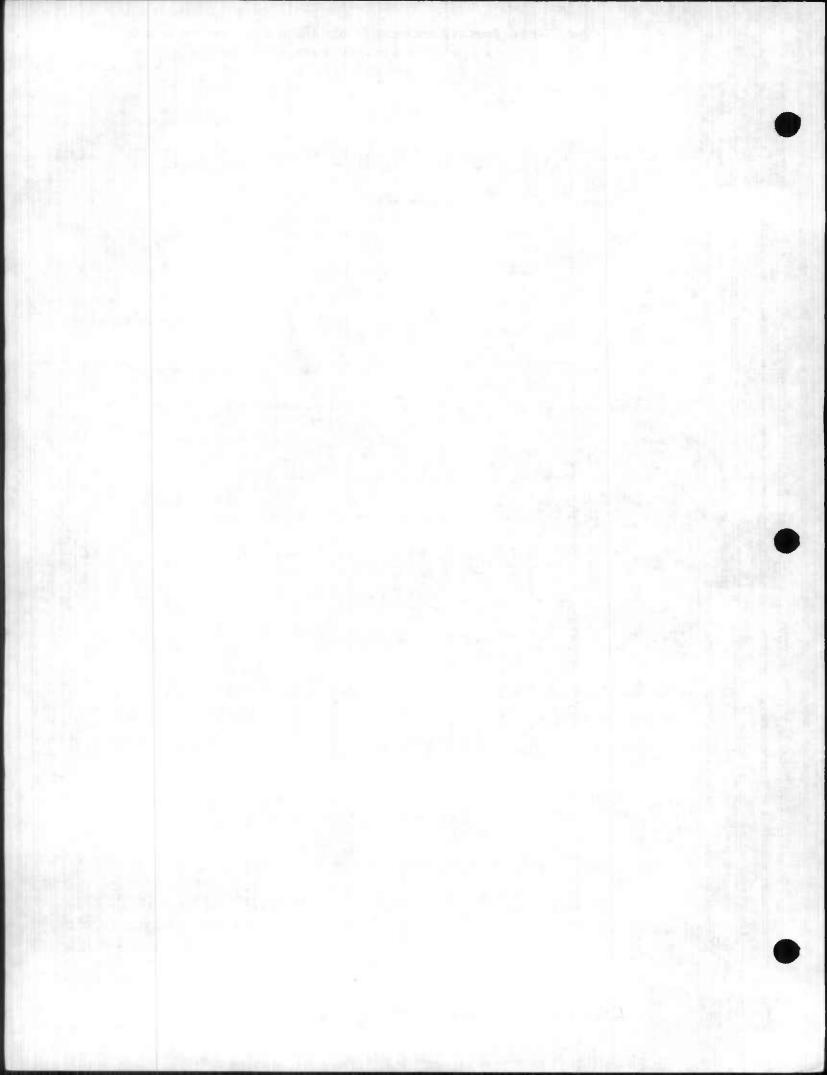
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEIHNDRO

405 Frederick Ld. Baltimore My 21228-

State Registrar 31. Date filed (Month, Dey, Year) AUG 0 4 2000 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month Aug. 4, 2000 **Physician** Harold Cecil Haines 3 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reisterstown 7 Wolf Ave. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 3, 1920 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpteca (State or Foreign Country) **Funeral** Months Days Hours 1 □ XM 2 □ F 218-09-7281 79 Yrs. Maryland Director Usuai Rasidence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Md. Baltimore Reisterstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21136 7 Wolf Ave. U.S.A. 238 Funeral filed within 72 hours efter deeth 14. Race - Americen Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) or items 1) Yes 2 No If Yas, Giva Year or Dates: WW 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced "neturel", Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Trucks Mechanic 7 is marked other 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Heelth end Mental Maggie Bowers William Roy Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Heelth el important: If Item 27 is any Injury or other trau Margaret M. Haines - Wife 7 Wolf Ave., Reisterstown, Md. 21136 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 4, 2000 Baltimore, Md. Metro Crematory 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel 23a. Parf. Enterthe diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onsat and Death **Physician** immediate Cause (Final disaasa or condition resulting In death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NONE Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy page 2 should this cartificate has 1 Yes 2 No 1 Yes No is after death.

Signature: After this cartificate of in by the funered director; pa 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Nasidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funers! Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of death (Hem 23a) (Type, Print) RALG 210 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 2000 AUG 0 4 **DHMH 16 Rev 6/95**

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	Decedent's Neme (First, Middle, La	st)	Cer	tificate of	Death	2. Date of De			3. Tima of Death		
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edicai iminer	4a Facility Nama (If not institution, giv			THE	4b. City, Town, or L	ocation of Deeth	4c. County	of Death			
	Gilcrest Cen	ter			Towson		Bal	timo	re		
eral tor	214-30-4079	ax 7. Age (In y	rs. last birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 1	th y, Year) 6,1939	9. Birthpl Count Md	ace (Stata or Forai try)		
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Direct	10e. Street and Number 714 Gregwood	7+	ind briga	10f. Zip Coda 2 1 2	22		10g. Citizan of V	Vhat Count	try?		
by Funeral Director	11. Marital Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedant Evar in Armed Forces? 1 ☐ Yas 22 No If Yes, Giva Yaar or Datas:	H	/as Decedant of I	Hispanic Origin? (Sp an, Mexicen, Puerto	- 14. Race Blace	e - Amarica k, Whita, a Whi	itc.			
pete	15. Decedant's Ec (Specify only highast gra	lucetion de completed)	16a. Deced	ent's Usual Occup	pation	kina	16b. Kind of Bu	sinass/Ind	lustry		
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5	19a. Informent's Neme/Ralationship (Turno Print	10h Mailio	Addrage (Street	and Number or Ru			State 7in	Codel		
21 August 21 August 23 August 23 August 23 August 23 August 23 August 24 August 25 Aug	Cindy Bartholow daughter 247 Green Furn Way Halethorpe, M 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Nama of cematary, cramatory or other place) Christ Luth. Cem. Aug. 3 Dundally										
	21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222										
	23a. Part1. Enter the disease, or com	olications that caused tha d	laath. Do not ante	r tha moda of dvi	Lers Po	or raspiratory e	. 2122.	2	Approximete Interval Batween		
	23a. Part1. Enver ha disaasa, or complications that daused tha daath. Do not anter tha moda of dying, such as cardiac or raspiratory errest, shock, of beart failure. List only one causa on aach lina. Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of):										
iner									U		
cai Examiner	b. Dua to (or as a consequence of): if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants Due to (or es e consequence of):										
0	rasulting in death) Last	d	o (or es e consequ	ierice or).							
icia	Part II. Other eignificant conditions of	potributing to death but not	rasulting in the ur	darlying causa oi	van in Part I	23h Did	23b. Did tobacco use contribute to the cause of de				
/ Physician/Me	Tarti. Salar eigimouri conditions o	variant airt.		Yee 2/2/No		pably 4 Unkno					
Completed by							an autopsy ormed?	ava	are autopsy findings ailable prior to mplation of causa daath?		
mo:						10	Yas 2 No	1[Yas 2 No		
Be	25. Was cesa refarred to medical axaminar?				26. Placa of Dea	th (Check only o	ona)		11		
6	1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding	Hospital: 1 Inpatient 2 28a. Data of Injury (Month, Dey Year	2 ER/Outpation 28b. Tima of Injury	3□ DOA Ot		ome 5 Rasi	dance 6 POth how Injury occur	ar <i>(Specif</i>) red	ntospi		
Certification:	2 Accident invastigation 3 Suicide 6 Could not b 4 Homicida detarmined	1]Yas 2□No	28f. Location (City or To	Street and Numb wn, Stata)	er or Rura	I Route Number,		
edicai C	(Check only 2 Medical Exam	yelcian: To the best of my laner: On the basis of axam									
Medical Co	29b. Signeture and title of certifier	and mannar statad.		29c. Licen	se number		294, Data signe	d (Month	Day Vearl		
	A Anthon	ykile,	cuo	Da	5205	/	Augus	41	, 2000		
	AND DESCRIPTION OF THE PERSON NAMED IN COLUMN 2 IS NOT THE OWNER, WHEN PERSON	ACCUMULATION OF THE PARTY OF TH									
	30. Name and address-of person who	Confidented cause of death (Itam 23a) (Type,	Print)	N. Cl	rarles	D. 1	Bal	Ho. ml		

9HMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Year **Physician** 2000 6:29AM 141 /Medical 4c. County of Death 4b. City, Town, or 4a Facility Name (If not institution, give street and number) Lecation of Death **Examiner** N/A DAYLERE DAUI If Under 24 Hrs. AEN EMORE If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 7, 1946 Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 200 F 53 212-46-8590 Yrs Director Md. Usual Residenca of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County 23a or 28a-f ahon the Medical Examiner must be notified at Dundalk Md. Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1950 Frames Rd. Funeral Neme 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Yas 2 ☑ No If Yas, Give 1X Navar Married 2 Married 0 Maryland 21215-0020 Specify: White 1 Yas 2X No Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etamantary/Secondary (0-12) Collega (1-4or 5+) yrs. Clerk Mail other 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Peges 1 end 2 should be nent of Health end Mental ant: If Itam 27 Is marked or Helen Nomick Norman Holthaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) permit. Peges 1 end 2 Department of Health e Important: if Itam 27 is any injury or other tra 1950 Frames Rd. Dundalk Md. 21222 Gabriel Johnson friend Baltimore, 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Aug . 4 , Metro Crematory Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Approximate interval Batween Onset and Death ter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, heart failura. List only one cause on each line. Physician /Medical immediate Cause (Finat disease or condition rasulting in death) Examiner Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be axecuted after deeth. Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last use as the burial-trar Due to (or as a consequenca of) P.O. Box 68760, the attending physician Due to (or as a consequence of): eral Director: After this certificate hes been signed by the a filled in by the funeral director, page 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, Be Completed by 24b. Were autopsy tindings available prior to complation of causa of death? 24a. Was an autopsy performed? 200NO 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatient 2 SEB/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 1 Naturai 5 Pending investigation 2 ☐ Accident 1 Yes 2 No 3 Suicida 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and mannar as steled.

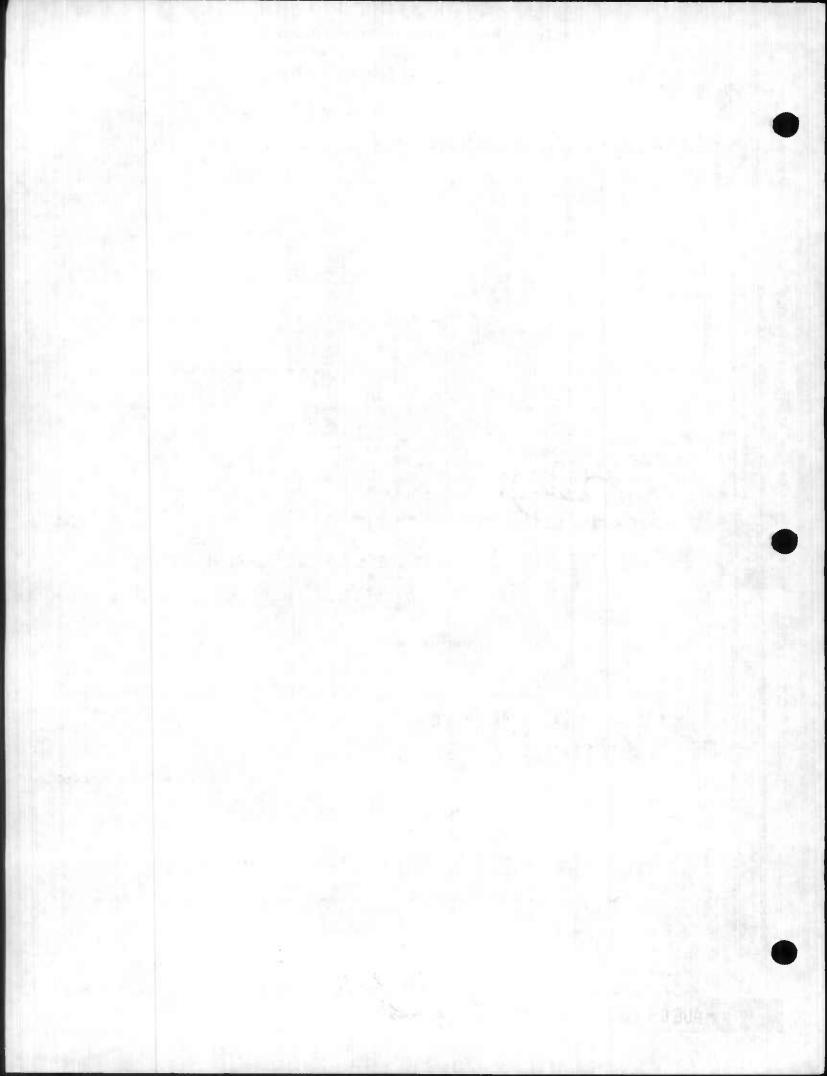
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and till of curtiful 29d Date signed (Month, Day, Year) w son who completed cause of death (Item 23a) (Type,

DHMH 16 Rev 6/95

Registrar

50 N ZA (GO

32. Registrar's Signatur



State of Maryland / Department of Health and Mental Hygiene [1] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **AMADA** HOUSTY 2000 August 12:55 am 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LONG GREEN CENTER/GENESIS ELDER CARE

To Age (In yrs. last birthday)

Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2⊠X Yrs 85 JULY 30, 1915 GUYANA 10c. City. Town or Location 10d. Inside City Limits XX Yes 2 No BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 21244 U.S.A. 3311 RIPPLE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Rece - American Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2X No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

the Maryland r 28a-f show Examiner must be a 72 hours efter death "natural", or h end Mentel Hygiene.
7 is marked other than "nature traumatic event, the Medical filled within permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If item 27 is marked oths any injury or other traumatic event bace.

Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

BERYL

5. Social Security Number

214-98-1964

10a State

MARYLAND

12yrs

10e. Street end Number

3 ☐ Widowad 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

CROMPTON HOUSTY

4 ☐ Donation 5 ☐ Other (Specify)

21. Signeture of Furnaral Service &

19a. Informant's Name/Relationship (Type, Print)

Henrietta Hestick/Neice

™Buriel 2 Cremetion 3 Removel from State

Director

Funeral

è

Completed

Be

2

Usual Residence of Decedent

10b. County

N/A

College (1-4or 5+)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t.

Physician /Medical Examiner

certificate be executed attending physician and for use as the buriel-transit signed by the a P.O. thet Records, should peeu The law page 2 hes certificate Division of Vital Physician: this funerel After t or Attending

in 24 hours effer death.
The Funeral Director: Aft Hospital within 2 ş

Physician/Medical Examiner þ Completed Be 10 Certification:

> State Registrar

edical

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA weren 1206 W NORTH AVENUE sass, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, unit List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MINURE Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury CardiovAscular Disease pertensive thet initiated events resulting in death) Last Due to (or as a consequence of):

SEAMTRESS

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT ZION CEMETERY

22. Name and Address of Facility

1 Yes 2500 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Naturel 2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and ente of certifier 29c. License number

30 hame and address of purson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 3 2000

SEWING

20c. Location - City or Town, State

BALTIMORE, MARYLAND

23b. Did tobacco use contributa to the causa of death?

Approximate Intervel Between Onset and Deeth

Years

18. Mother's Name (First, Middle, Maiden Sumame)

Date

8-9-00

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

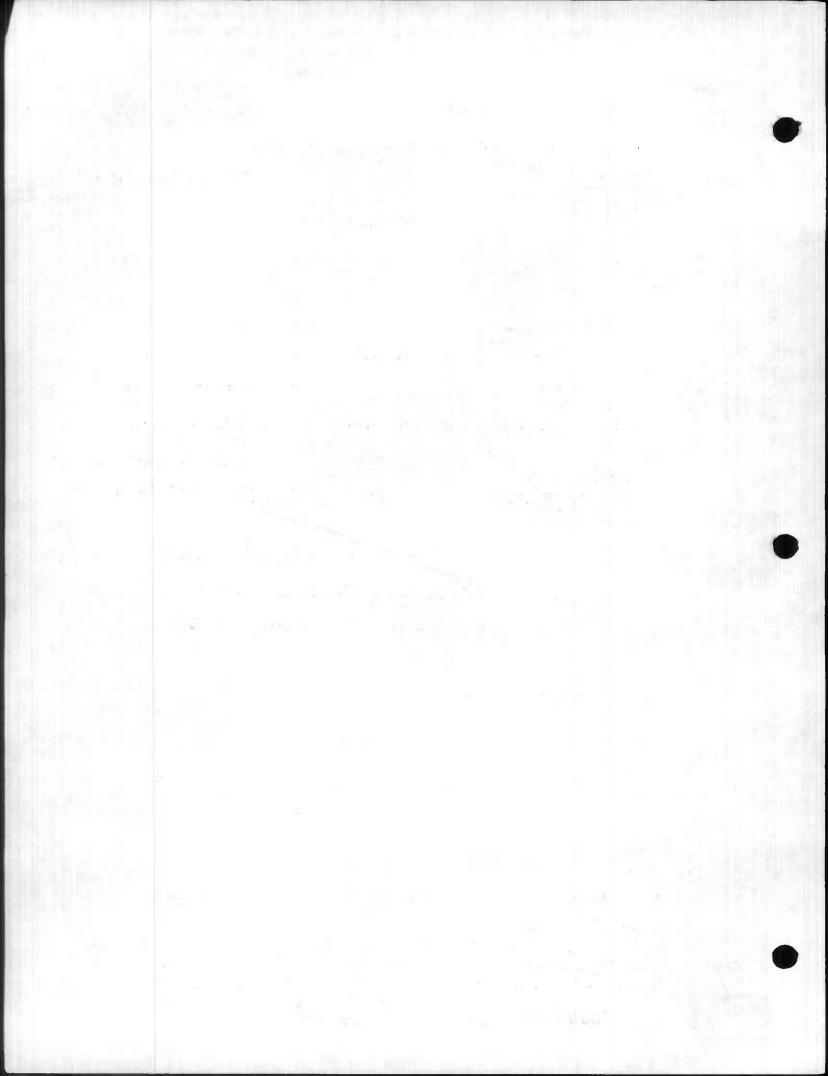
3311 RIPPLE RD., BALTIMORE, MARYLAND 21244

HENRIETTA HOUSTY CUMMINGS

SUMBARTZ M.D. 115 F Metrose Ave 21212 law 31. Date filed (Month, Day, Year)

Asteral No

AUG D 4 2000 32. Registrer's Signature



Phys /Me Exar

Funer Directo

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Hema 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar must be notified as

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.

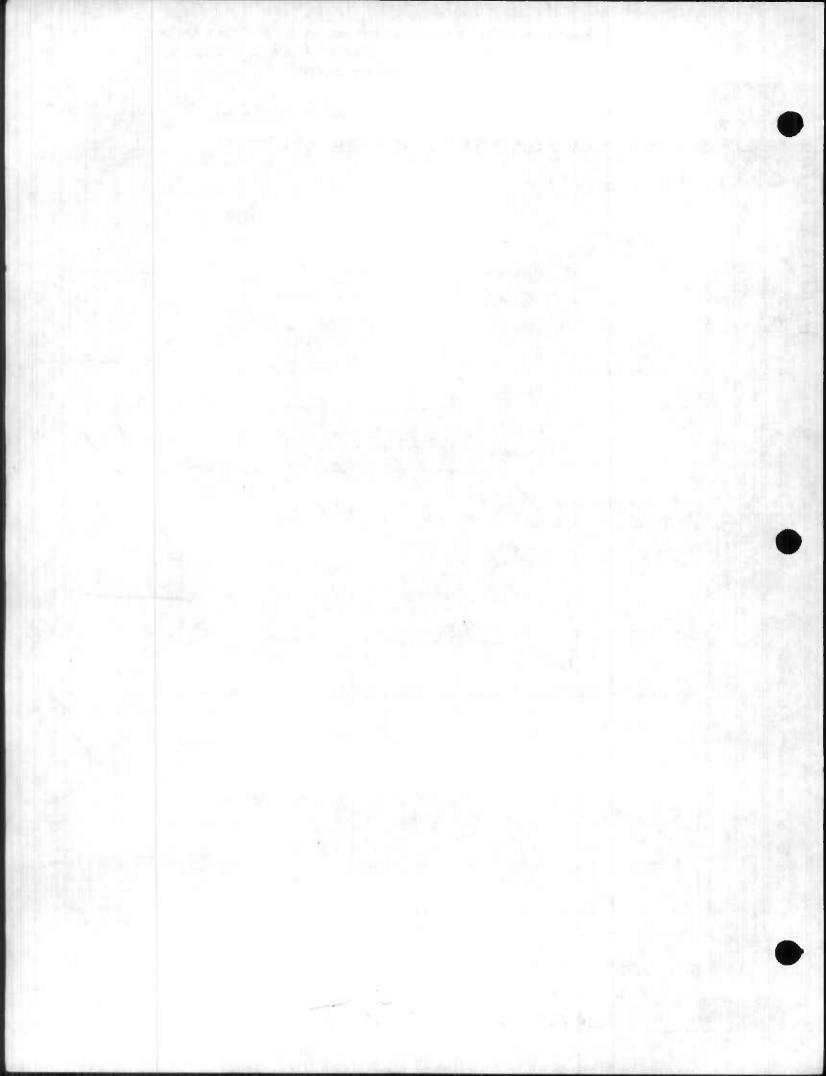
To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Cople

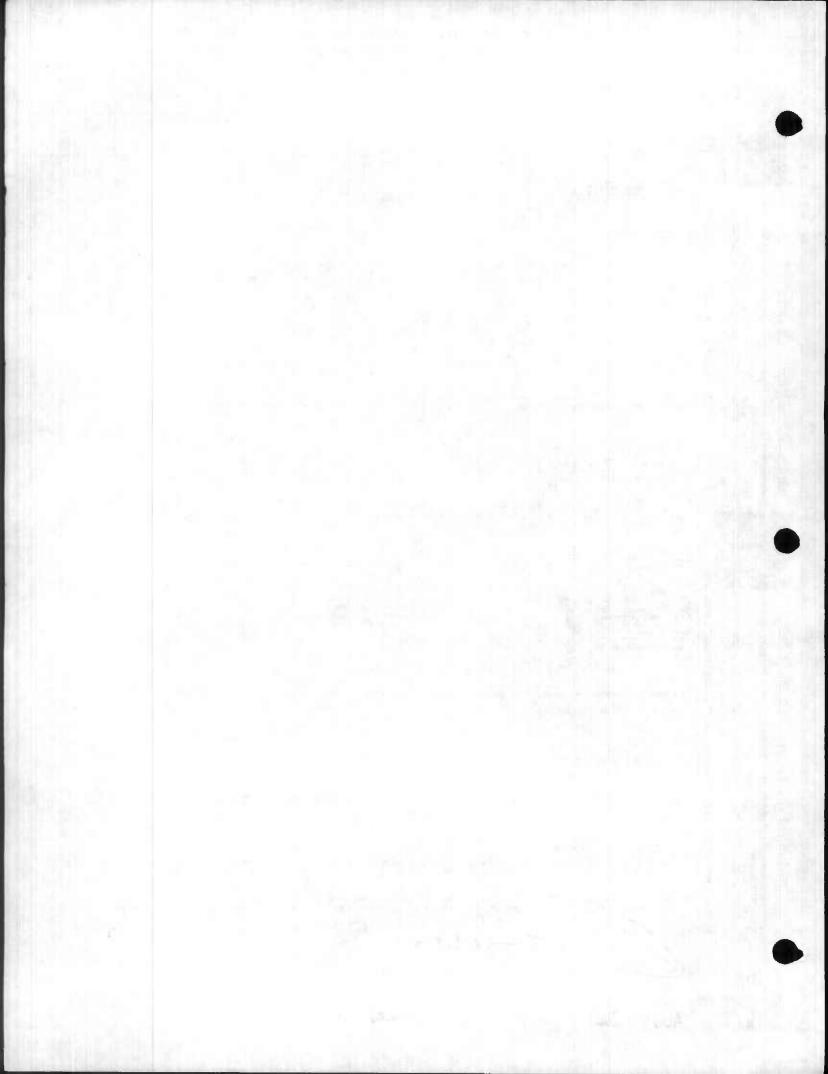
State of Maryland / Department of Health and Mental Hygiene 00

	lle, Last)					2. Date of Dea			3. Time of Deeth
William	E. Harr	ai a				Month	Day	Year	9:10 An
				4h Cihi	Town or L	ocation of Death	01 4		7.10 111
4a Facility Name (If not institution	0	- 0 -	31 - 0				4c. Count		
MAKATAU	O GEN	EKAL	_ HOSPI			MORE		year 2000 9.10 unty of Death NA 9. Birthplaca (State of Country) NC. 10d. Inside Cit 12 Yes of What Country? A Race - American Indian, Black, White, etc. ecity: Black of Business/Industry Consture Turner mame) own, State, Zip Code) 2: ore, Maryl- on-City or Town, State No OOO Owings aryland 21: rth Avenue Approximate Interval Bety Onset and E	
5. Social Security Number	1 RM 2 F	Age (In yrs. last	Months		der 24 Hrs.	8. Date of Birth (Month, Day	h /, Year)	9. Birth	placa (State or Fore ntry)
245-01-8495	A	84	Yrs.			07-28	3-16		NC
Usual Residence of Decedent 10a. Stata 10b. County	,	10c City T	Town or Location					1.	10d Incido City Limi
Toa. Stata Too. County									
MD NA		Balt	timore	Sec. Land	100				1X1102 201
10e. Street and Number			10f. Zip				10g. Citizen of	What Coul	ntry?
1508 Harford	d Avenue A	Apt.#10	03 21	213			USA		
11. Marital Status	12. Was Deceder	nt Ever in U,S.	13. Was Dece	dant of Hispanic cify Cuban, Mexi	Origin? (Sp	ecity Yas or No-	14. Ra		
1 Never Married 2 Mar						rican, etc.)			
3 ₩idowed 4 Divorce	d Year or Date:	s:	1 Yes	No Spec	ary:		Speci	y: B1	ack
15. Decede	nt's Educetion	1	16a. Decedent's Usua	al Occupation			16b. Kind of E	Business/In	dustry
(Specify only highe	est grade completed)	V E ()	(Give kind of wo	ork done during n se retired)	nost of work	ang			
Elementery/Secondary (0-12)	College (1-4d	л э+)	Lahona				White	& T	onsturct
7th Grade 17. Fathar's Name (First, Middle)			Laborer	18. Mc	other's Nam	e (First, Middle,			arner
Ed									
	Harris		405 14.20	Mai	-		unt	04 1	0-41
19a. Informant's Name/Relation	ship (Type, Print)	1	19b. Mailing Address	s (Street and Nui	mber or Rui	ral Houte Numbe	ir, City or Town	, State, Zij	2121
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20a. Method of Disposition Surial 2 Cremation	3 Demoved from Cto		e of Disposition (Nate of Contract of Cont	me or othar place)		Date	20c. Location	- City or To	own, State M.D.
4 Donation 5 Other (Specify)	Gar	rison F	orest 1	VA Co	m 08	04-20	20 0	
21. Signature of Funeral Service	Licensee			nd Address of Fa	cility				-
1/1.	1	/			Ba	altimor	e, Ma	ryla	nd 21202
23a. Rart1. Enter the disease, o shock, or heart failure. Lis	of our	7	WM.C	March	1 FH	1101 E	Nor	th A	venue
disease or condition resulting in death)	a	5.5						1	21-11
resulting in death)	s. My	Due to (or as	s a consequence of): // A C	nfar	ction	U		1	
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State of Maryland / Department of Health and Mental Hygiene 00 24689

							0, 5	Death			Reg. No.		
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sician edical	ELIDA	ILLBACK								JULY	30, 20	000	8:15 P.M
iner	4a Facility Nama (mber)			4	b. City, To	wn, or Lo	ocation of Death	4c. Count	ty of Death	
		K NURSING		7 Ann (In comp. In	and bringly what is	If Undar 1	Veer	BALT		E CITY		N/A	
	5. Social Security N 093-10-4		Sex 1 M M F	7. Age (In yrs. la 90	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day 4/7/10	y, Year)	NEW NEW	pplace (State or Foreign untry) JERSEY
	Usual Residence of	10b. County		10c. City	. Town or Lo	ocation							10d. Inside City Limits
CIOL	NJ	BERGE	N		ESTWO								1 Yes 2 □ No
Directo	10e. Street end Nu					10f. Zip 0	ode				10g. Citizen of What Country?		
	-	TON AVEN					7675				USA		
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and division of	/Sne	15. Decedent's E	Education		16a. Dece	dent's Usual kind of work	Occupa done	ation	t of work	ina	16b. Kind of	Business/I	ndustry
	Elementery/Second 12 YEAR	ondary (0-12)	College (1	1-4or 5+)	life.	DO NOT use RETARY	retired)			INSURA	ANCE	
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	PETER	ILLBACK			14.18			ANN	A MA	RIE SAL	VESEN		
	19e. Informant's N	lame/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numbe	er or Aur	al Route Numbe	er, City or Town	n, State, Z	(ip Code)
	LYNN IL		N	IECE		CIPR) WOOI	DS C		HAM, MI		706
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Physician /Medical Examiner	4a Fecility Name (If not institution, go		la Johns	S	4	7 11	yn, or Location	4 5	4c. County	of Deeth	08:57
Funeral Director		HOSPITAL Sex 7. A	ge (In yrs. last bir	thday) If Und Month	ler 1 Yeer s Deys	oatt If Under 2 Hours	Min. 8. Dat	e of Birth onth, Day, Ye Dec 6, 1	ar)		re City ace (State or Fore ry) RYLAND
	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location				Dec 0, 1	340		od. Inside City Lim
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r. or Hama Framiner m by Fune	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 I	Year or Dates:				in? (Specify Ye Puerto Rican,	pecify Yes or No- o Rican, etc.) 14. Race - A Black, V Specify:			
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merked other mettic event. To Be C	17. Fether's Name (First, Middle, Las Jame 19a. Informent's Name/Relationship	es Kellley	196	. Mailing Addre	ss (Street			ame (First, Middle, Maiden Surname) Gertrude Thompson Rural Route Number, City or Town, Stete, Zip Code)			
t of Health ar If them 27 is or other trau	Mr. Emn 20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3	20b. Placa of		ges Lar	ne Caton	nsville, Mar	ille, Maryland 21228 Date 20c. Location - City or Town, State 07/31/00 Ellicott City, Maryla				
hysician /Medical xaminer Example Example Exam	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in deeth)		Due to (or as a	PD consequence of	ex a		nbia Pike E cardiac or respi		y, w.b. z.		Approximate Interval Between Onset and Death
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within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer Medical Certification:	29a. Certifier 1 Certifying P	thysician: To the best miner: On the basis and manner s	of my knowledge				d placa, and du	e to the caus	e(s) end ma		
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	30. Name end address of person who Martins Ug 31. Date filed (Month, Day, Year)	wu-Dike	death (Item 23e)	Type, Print)	Ca	ton 1	Ave.	BaH	imor	e, M	d. 2125

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

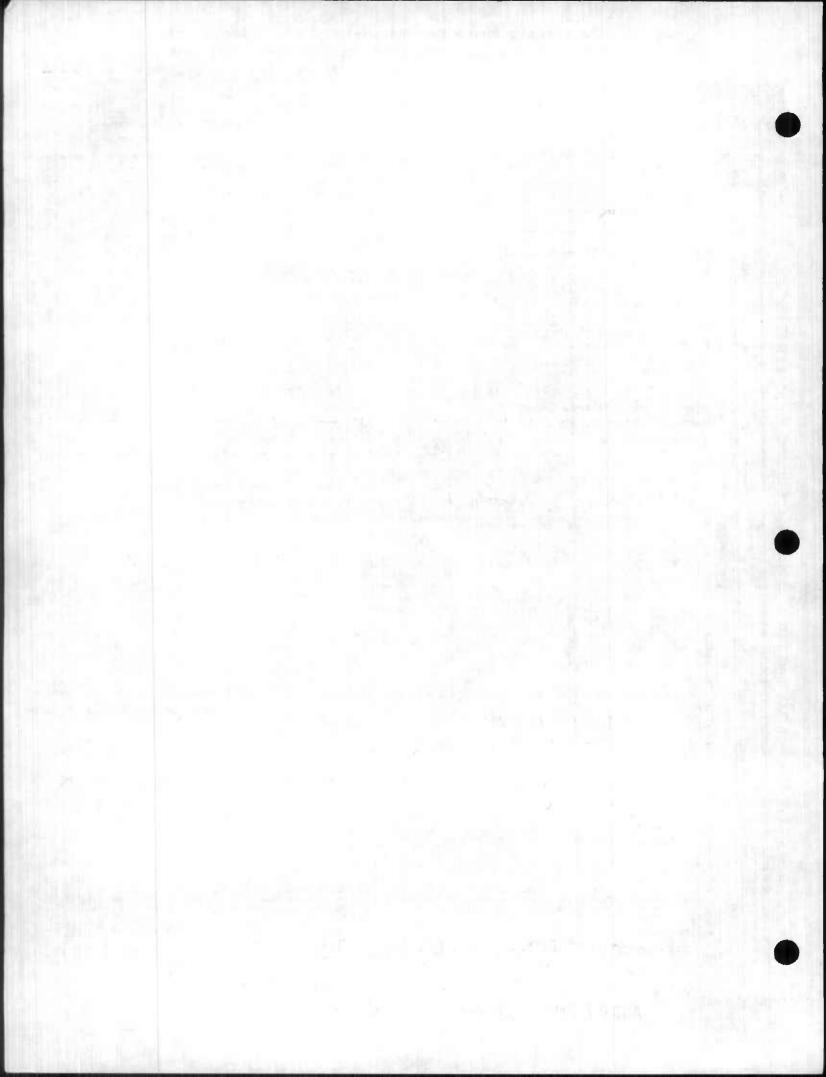
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° Funeral Director		M 20 F 74	Yrs. Months			Year) 26	9. Birthplaca (Stata or Foraign Country)
yland	10a, State 10b. County		Town or Location				10d. Inside City Limits
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	1230 SILVER	12. Was Decedent Evar in U.S	4 2	1239	Specify Ven or No	U. 5.	- American Indian,
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Physician	23a. Part. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death. na cause on each line.	Do not enter tha mo	da of dying, such as cardia	ac or respiratory arra	ıst,	Approximete Intarval Batween Onset and Death
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Division of within 24 house after death within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral	27. Mannar of Death 1 Natural 2 \ Accident 3 \ Suicide 4 \ Homicide	28a. Pleca of Injury - At hon building, atc. (Specify)	na, farm, straat, facto	ry, offica	28f. Location (St City or Town	reet and Numbe ı, Stata)	r or Rural Routa Number,
e Hospit 124 hour 6 Funeral	29a. Cartifier 12 Certifying Phy	elclan: To the best of my know ner: On the basis of examinationand menner stated.	ledga, daath occurre on and/or invastigatio	d at the time, date end place n, in my opinion, death occ	ce, and dua to the courred at the tima, d	ausa(s) and man ate and place, ar	nar as stated. nd dua to tha cause(s)
To th To th comp	29b. Signature and titla of certifiar	HAT HELDER		9c. License number			(Month, Day, Year)
	Elaind G.	Kanlan, N	0	00021283	(ingust	2, 2000
5	30. Nama and addrass of person who co	omplated cause of death (Itam	23a) (Type, Print)	ROUM \$853, P.	SALTIMORE,	WD 3130	Pc
Sta	31. Data filed (Month, Day, Year)	32. Registrar's Signatu					
Registra	ALICA A GOOD	General 19	Ann V				

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State of Maryland / Department of Health and Mental Hygiene

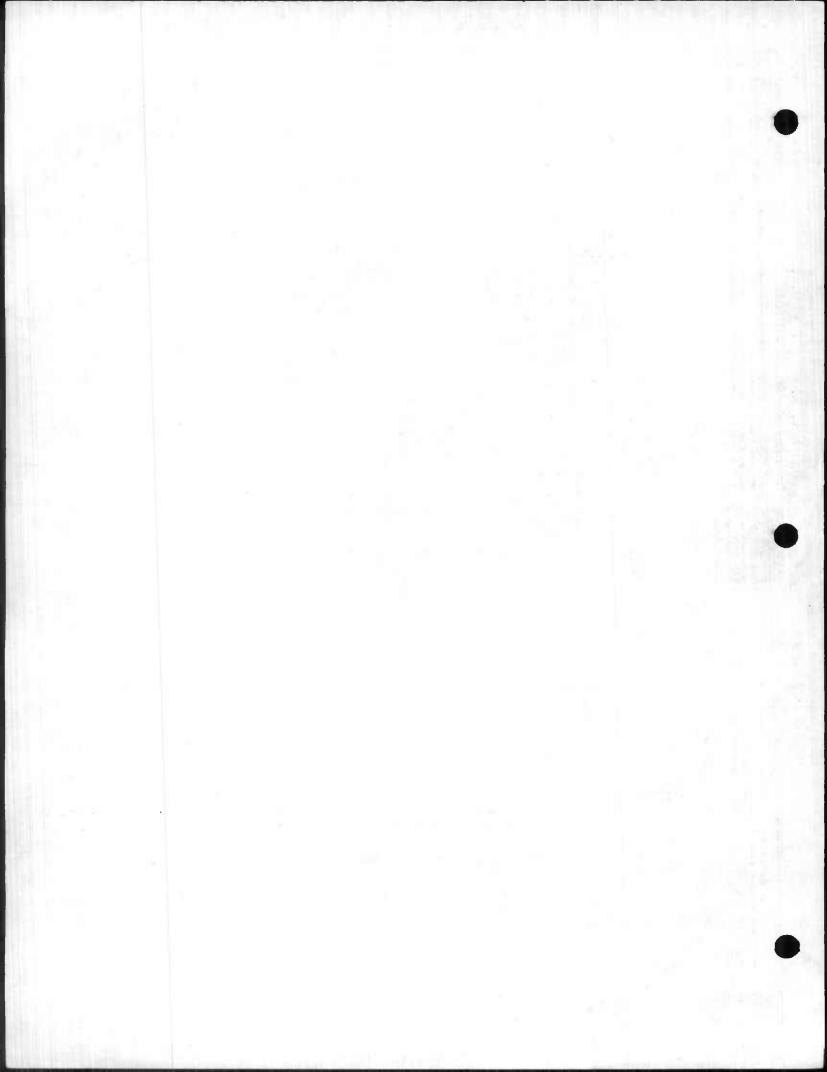
					Certificat	e of l	Death			Reg. No.	0	24072
		1. Decedent's Name (First, Middle	a, Last)		III A				2. Data of Dec	ath Day	Yaar	3. Time of Death
40,	Physician /Medica	(-2-	therine Dor	is Kotm	air				August			11:10 PM
	Examine	de Casilla diama (Mana institution	, give street and number)			4	b. City, To	wn, or Lo	cation of Death	4c. Coun	ty of Death	
M		2006 Hillor	oft Drive				Fore	est F	Hill	Harford		
	Funeral Director	5. Social Security Number 216-30-9295	6. Sex 7. Ag	e (In yrs. last birth 88 Y	nday) If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 7-11-	y, Year) 1912	Cou	place (State or Foreign ntry) 'Yland
	9	Usual Residence of Decedent										
	28a-f show sofffind at	10a. Stata 10b. County Maryland Harfo	ord	10c. City, Town Fore		1						10d. Inside City Limits 1 ☐ Yes 2 No
	5 6 8	2006 Hillo	roft Drive		10f. Zip	1050				10g. Citizen o	S. A.	
020	hours after death variety or Herre 23 at Exemples must		12. Was Decedent Armed Forcas? 1 □ Yes 2 □ X If Yes, Give Yaar or Datas:		13. Was Dece ff Yes, spe	cify Cuba	ispanic Or in, Maxicai Specify:	n, Puerto	ecify Yes or No- Rican, etc.)		laca - American Indian, clack, Whita, etc. Cily: White	
21215-0020	ST and and	15. Decedent (Specify only highes Etementary/Secondary (0-12)	's Education of grade completed) College (1-4or s	54)	Decedent's Usu 'Give kind of wo life. DO NOT u	rk done d se retired	during mos	st of work	ing	16b. Kind of Own H		idustry
	led within lygiene.	10	1		Onemake		40.14-41		- Winn Alleddo			
Maryland	Tabe d	17. Father's Name (First, Middle,							e (First, Middle,		Ime)	
7	Marks with		thew Bauer					rene		nith		
Mai	Ta man	19a. tnformant's Name/Relations							al Route Number			
	teall m 27	Sister Rita A. 1	KOTMATI (Dau		Disposition (Na		OL L	DETAG	Date Date	20c. Location		
Baltimore	Pages ment of ant: If its ury or o	1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		camerery	crematory or o	ther plac	m. Ga	ards.	8-5-00			Maryland
Ball	Depart Depart Import any in	21. Signature of Funeral Service Licensee **Dudlace S. Brank Jr.** 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21										
П		23a. Part1. Enter the disease, or shock, or heart failure. List	complications thet caused	the death. Do no								Approximate Interval Between
68760,	Cheath certificate be executed by American Advances of a stranging physicien and for use es the burial-transit and for use es the burial-transit and for use es the burial-transit and for use and for the formula of th		a. ARTE b. ARTE	Due to (or as a co	onsequenca of)	SUS	c c	AR	DIO VAS DEVLA	c, c	ly	Onset and Death
Box 68	attanding pt for use as t		d									
0	at the death of	Part II. Other significant condition	ns contributing to death b	ut not resulting in	the undarlying	ausa giv	en in Pert	t.	23b. Dfd	lobacco use	ontribute t	to the cause of death?
٩	£ 90)14770N					_	10	Yes ZONO	3 □ Pro	obably 4 Unknown
Vital Records,	been should		MYTE	104	BAL	AN.	et			an autopsy rmed?	a	Vere eutopsy findings vailable prior to ompletion of causa f death?
al R	certificate hes rector, page 2		NETHUSI	CUTEN	INE) (10	JOE	R	10		1	□ Yas No
₹ 	Physician: this certific ral director,	examiner?	Hospitel:			Oth	er.		h (Check only o			
of	Phys ral di		1 L Inpatie			JA	4 🗆 14	ursing Ho	28d. Describe	denca 6 🗆 C		ity)
on	After funer	Neturat 5 Pendin	g 28a. Date of Inju (Month, Da	y Year) In	jury M	28c. Injur Wor	k? Yes 2□	No	1	U/A		
Division	is after deeth. In Director: After the funers of in by the funers.	f2	y, office			28f. Location (Street and Nur vn, State)	nber or Rui	ral Route Number,			
	Hospi 24 hou Funer tely fill		g Physician: To the best Examiner: On the basis of and manner st	f examination and								
	within 7 to the comple	29b. Signatura and title of cartifier	1	. ^	29	c. Licens	e number	7 7		29d. Date sig	ned (Month	, Day, Year)
	63484	1-Benc	Heyza,	M.D.	2	0	87	97		Aug	.3	2000
	10	30. Name and address of person	who completed cause of a	BEZ	ATR	, w	10	2	1014	U	t	
	State	31. Date filed (Manth Day, Year)	2000 32. Registr	ar's Signature	do do	als						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene O O

hysician		Decedent's Name (First, Middle, Last) Joseph Anthony Kyzour, Sr.							Mo	te of Deel	Dey Year		3. Time of De	
/Medical		Seph Anthony (If not institution, gir	, ,				14	b. City, Town, o		JUST	01 200 4c. County		7:30PM	
Examiner	Stella		ve street end num	<i>Del)</i>				Timonium	Cooditor	Di Douiri	Balti			
uneral rector	5. Social Security 220–05–058	Number 6.	Sex 1 M 2 □ F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Months	Year	If Under 24 Hours Mi	8. De	e of Birth onth, Day, Y 21			iaca (State or Fo	
1	Usual Residence	of Decedent		10c. Ci	ty, Town or Loc	cation						11	0d. Inside City L	
to to	Md.	Baltimore	e		ltimore								1 ☐ Yes 2X	
"naturel", or terms 23s or 28s-f show ideal Examinar must be notified at letted by Funeral Director	10e. Street and No. 2807 C	old Stream I	Way	10f. Zip Code 21234					10g. Citizen of What Country? USA				itry?	
		rried 2 Married	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or De	ces? 2 🖄 No		Ves Decede f Yes, specif I ☐ Yes 2		spanic Origin? on, Mexican, Pue Specify:	Specify Yearto Rican,	etc.)	Specify:			
led be		15. Decedent's E	ducation	.00.	16a. Deced	lent's Usuel	Occupa	ation furing most of w	ndine.		16b. Kind of B		white dustry	
event, the Wederlines Be Completed	Elementary/Sec	condary (0-12)	College (1-	4or 5+)					orking		Dadla7 ala	C+-	01 3	
CO	17. Father's Neme	E (First, Middle, Last	')	Ship Ya			Yard Worker			eme (First, Middle, Mi		em Ste	eı	
To Be		es Francis H						Mary Ka	therir	e Sle	chta			
	19e. Informent's N	Name/Relationship	(Type, Print)		19b. Meilin	g Address (Street a	and Number or i	Rural Rout	Number	City or Town,	State, Zip	Code)	
70.		M. Baumer/	Daughter					e. Balti	1					
any injury or other traumatic event, the Minne. To Be Comp		•	20b. Place of Disposition (in cametery, crametory) Most Holy Redection				ry or other plece)				Baltimore, Md.			
y injur		Funerel Service Lice		1 103	22.	. Name and	Addres	s of Facility	1		baremor	C, IN.		
any i	1 K	SIL	Laugh	res	1	KUCK 10 050 Yor	wson k Rd	Funeral L. Towson.	Home,	inc.				
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CS 00-4242-003 Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. MICHAEL KERNS amend item 8 per fh G786 8/18/00 State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 28A-F PER MED Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** MICHAEL KERNS JULY 30 2000 16:40 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner 620 SHIPLEY ROAD ANNE ARUNDEL LINTHICUM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 101M 20 F 216-94-7120 20 Yrs. DEC. 2030 1979 Director MARYLAND Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f short the Manyla 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL LINTHICUM 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **За 23в ог** the Medical Examiner must be 620 SHIPLEY ROAD 21090 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Give 1 Never Merried 2 ☐ Married ò Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify WHITE Specify à 3 Widowed 4 Divorced Year or Detes Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TITLE ABSTRACT 12 TITLE/ABSTRACTOR 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Mental 8 RICHARD LEE KERNS BRENDA F. 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) MRS. BRENDA KERNS-WOOD (MOTHER) 620 SHIPLEY ROAD, LINTHICUM, MD. 21090 Hem 27 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages I AUG. 5. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK2000 ELKRIDGE, MARYLAND 22 Name and Address of Facility SINGLETON FUNERAL HOME, P.A., M00795 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 in properties of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, list only one cause on each line. Approximate tntervel Betw Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical METHADONE INTOXICATION Examiner Due to (or es e consequenca of) Physician/Medical Examiner The lew requires that the death certificate be executed es the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury Due to (or es e consequence of) and Box 68760. attending physician thet initieted events resulting in death) Last Due to (or as a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. ate has been signed by page 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown by of Vital Records. 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed Yes 2□ No 1 X Yes 2 No this certificate Physician: eral Director; After this certific filled in by the funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify SCENE 1X Yes 2□ No 10 28e. Dete of Injury FOUND: Dey Year) 7-30-00 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 27. Menner of Death Division Attending 1 Neturel rending investigation FOUND: UNKNOWN 1 Yes 2 No M death. 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Bural Boute Number City or Town, Stete) 620 SHIPLEY RD. after a 4 Homiclde FOUND: RESIDENCE LINTHICUM, MARYLAND To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) and menner steted. Medical 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. JULY 31, 2000

State

DHMH 16 Rev 6/95

AUG 0 4 2000 31. Dete filed (Ma Registrar

, m.D. RIPPLE 32. Registrer's Signeture

30. Name end address of berson who completed cause of deeth (Item 23a) (Type, Print)

G.

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene

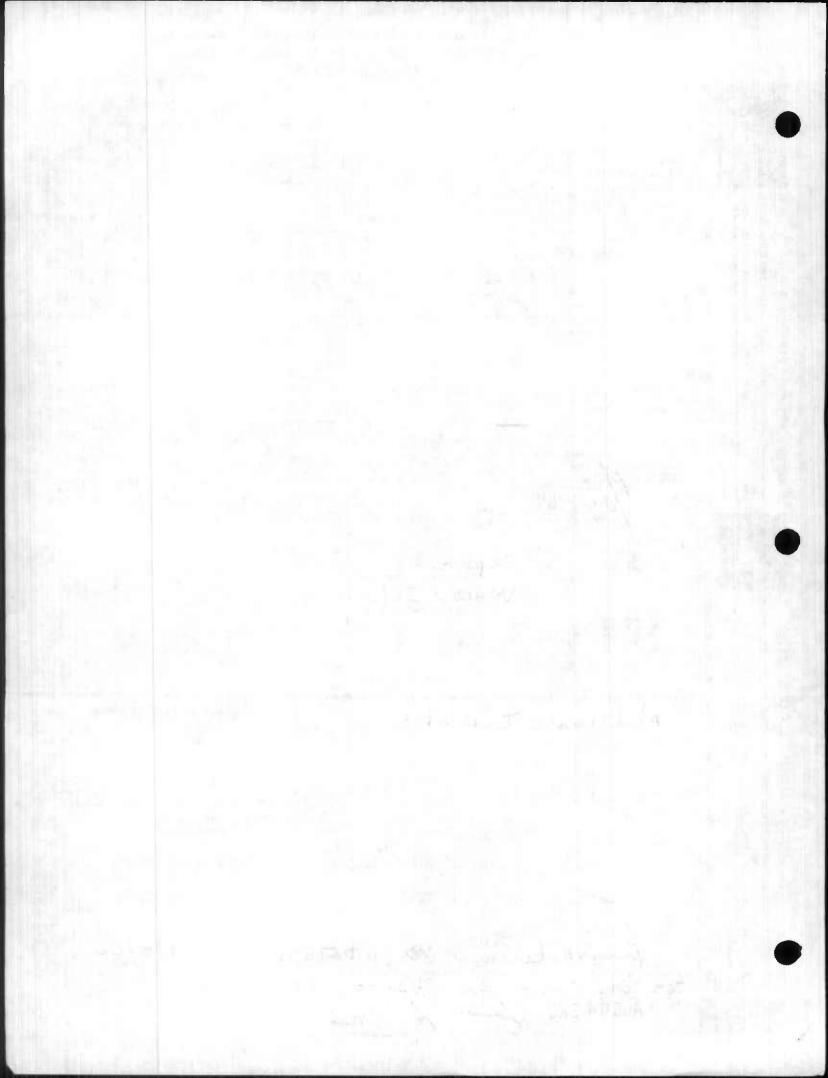
AMENDED ITEM 19a PER FH G786 8/4/00 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death . 2000 **Physician** BELLE KLOZE AUGUST 2, 8:15 AM /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ONE POMONA EAST #311 BALTIMORE BALTIMORE If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 M F 93 Yrs RUSSIA 219-12-6682 AUG. 6, Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Director MD BALTIMORE the Medical Examiner must be notified BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Nerne 23s or ONE POMONA EAST #311 21208 U.S.A. Funeral Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S Armed Forces? 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Nevar Married 2 ☐ Married ò Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: Àq WHITE 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Mental 8 **JACOB BECKER** BESSIE WINOGRADSKY 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) .89 Pages 1 and 2 Health: BARBARA SHAPIRO / STEPDAUGHTER 1008 ST. GEORGES ROAD - BALTIMORE, MD 21210 Saltimore, 20b. Ptece of Disposition (Name of cematary, crametory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 8/3/00 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 edisease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, failure. List only one cause on each line. 23a. Pert1. Enter Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest use as the burial-fran Box 68760 attending physician Physician/Medical Dua to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Wara autopsy findings evailable prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed this certificate has 1 Yes 2 No 1 Yes 2 PNO Be Attending Physician: 25. Wes cese referred to medical 26. Pleca of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1□ Yes 21 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of Injury at Work? After 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident versi Director: / 3 Suicide 6 Could not be 28a. Plece of tnjury - At home, ferm, streat, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) or A sefter 4 Homicide To the Hospital within 24 hours a To the Funeral E completely filled Hospitai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end mennar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner steted. edicai 29a, Certifier 29b. Signature at 29c. License number 29d. Date signed (Month, Dey, Year) d till of certifier 00 MD D51896 en rededress of person who completed cause of deeth (Item 23a) (Type, Print)

5 6 6 8 BAC d NO BALTO 21208 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

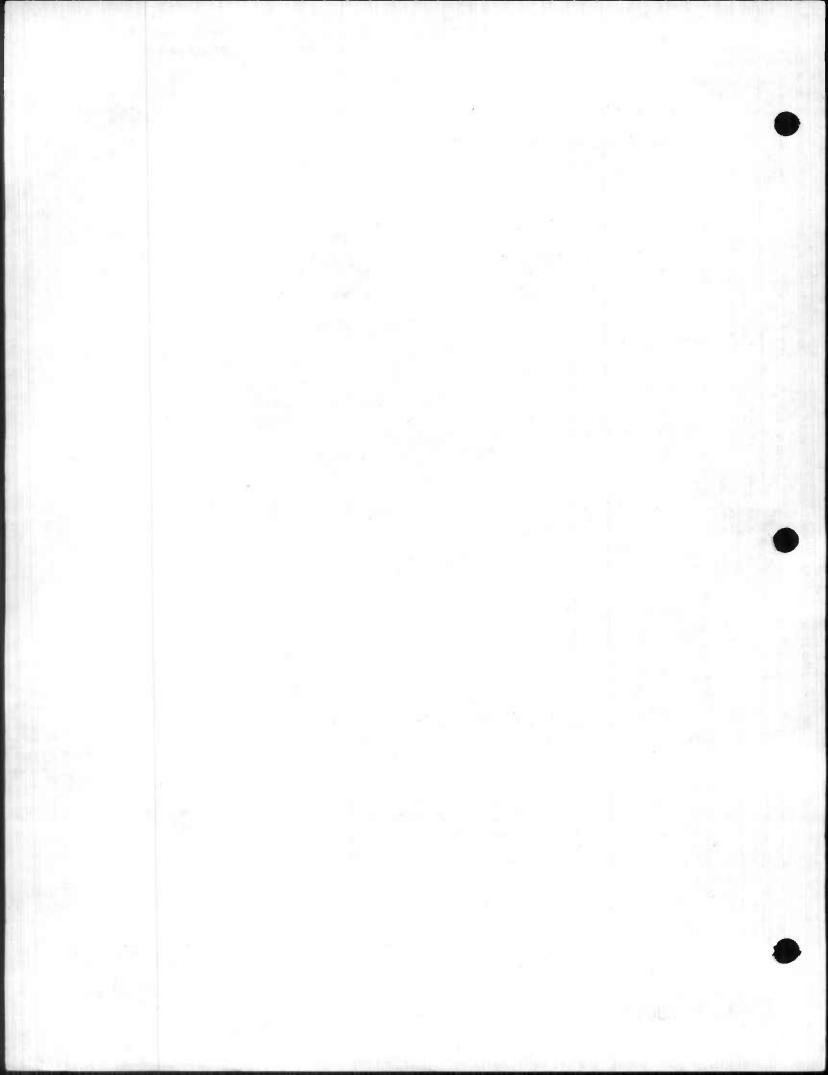


State of Maryland / Department of Health and Mental Hygiene 24696 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** LESTER JOSEPH 18=51 1 314 31 HICHOLAS 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GENERAL HOSP HALFORN FALLSTON FALLSTON 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number 6. Sex Birthplece (Stete or Foreign Country) **Funeral** Months 12 M 2□ F Yrs. Director 070-38-0863 New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-t show 1 Yes 2 No Directo Forest Hills Harford 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 'natural', or flams 23s or 2047 Edward Manor Drive 20150 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. hours after 1 ☐ Never Merried 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced Yeer or Detes: White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Maintenance Auto Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked Francis S. Lester To Florence Vecsey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health at important: If item 27 is any injury or other traughts. Wife 2047 Edward Manor Drive Forest Hills, MD 20150 Zoila Lester 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 08/05 4 ☐ Donetion 5 ☐ Other (Specify) Sleepy Hollow Cemetery Sleepy Hollow, NY 22. Name end Address of Fecility
Sterling Ashton Schwab Funeral Home, Inc. 21. Signeture of Funerel Service Licensee Volter Pubus 736 Edmondson Ave, Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel ASCUD diseese or condition resulting in deeth) **Examiner** Due to (or es e consequença of): Physician/Medical Examiner attending physician and for use es the burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. Due to (or es e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? o 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTHY ROIDISM Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? Exoquals OBESITY page 2 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific director. 25. Was case referred to medicat examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Certification: To funeral 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) á 4 - Homicide 2 pelli 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier edicai completely (Check only one) To the To The F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 31, 2000 DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR MD BEZAIR MD 21014 5. PRABHU M.D .728 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State AUG 0 4 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene 00

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	and 2 should selth and Men 127 la marke er treumatic	1	9a. Intormant's Name Michael Ar			1aw	0	g Address (Si			al Route Numb dshaw	er, City or Town		ode)	
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Baltimore,	permit. Pages 1 and Department of Heelth Important: if item 27 eny Injury or other tr RRCs.	2	1. Signature of Funera			01		Name and A	ddress of Fac	ility		of Essex			
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Division	rs after death. el Director: After t ied in by the funers Centification:		2 ☐ Accident	invastigati Could not determine	be 200 Place	1 Yes 2 No			(Street and Number or Rural Route Number, Town, State)						
۵	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the		9a. Certifier 1	Certifying P	hysician: To the iminer: On the ba	pest of my kno	wiedge, death	occurred at the	na time, data	and place,	and due to the	cause(s) and m	anner as state	ed.	
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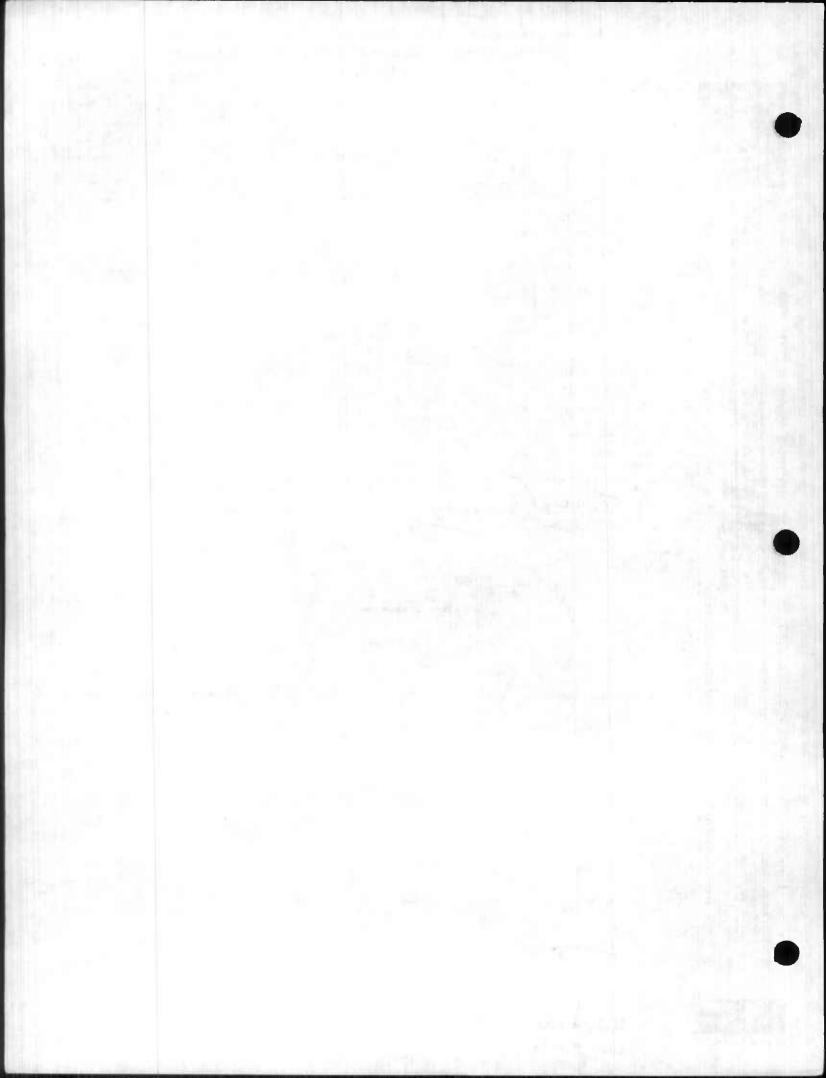
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32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 00 24698

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٠.	Funeral		5. Social Security Number	6. S	M 20 F	7. Age (In	yrs. lest birth		If Under Months	Days	Hours	Min.	8. Data of Bir (Month, Da 06/05)	th y Yeer)	9. Birth	plece (Stete or I	-oreign	
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^	0/0		30. Name and address of perso	n who	completed cau	se of death	(Item 23a) (T	ype, Pi	rint)	17.2	117							
1	169		Harjit Si							10	U 4 ~ b	1.10	Delt.		M.2 0	11225		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24699 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 1115 A FLLSWORTH LINDEMON Aug 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MEDILAL VA CENTER BATIMORE M Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** 215-18-0622 1 M 2 F 75 Nov. 6, 1924 Director Md. Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. N/A Baltimore City N Yes 2 No Director 288-1 10e Street and Number 10f Zip Coda 10g. Citizen of What Country? mant be n 1604 Joplin St. 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 Yas 2 □ No If Yes, Giva 14. Race - American Indian. Black, Whita, etc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: 21215-0020 b Specify: White þ 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12yrs. Driver Teamsters Frieght altimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked off lary or other traumetic even Be William E. Lindemon Sr. Margaret Dietrich 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Marie C. Wockenfuss Daughter 34 Dogwood Drive Baltimore, Md. 21220 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Aug 5, 1 Surlal 2 ☐ Cramation 3 ☐ Ramoval from State Oaklawn Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Dundalk, Md. 21. Signatura of Funaral Sarvica Licansaa 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part f. Enter the disaasa, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Littly only one cause on each line. Approximata Interval Between Onset and Death **Physician** immediate Ceuse (Finat disaase or condition rasulting in deeth) /Medical HYPOXIA 6 HAS Examiner Due to (or as a consequence of): Physician/Medical Examiner HUPOTENS:ON ACIDOSIS DUE TO 6 HRS The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Records, P.O. Box 68760, CANCER MNKNOWN MONTHS LUNG the Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the ACCIDENT NO Yes 2 No 3 Probably 4 Unknown VASCULAR þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? FISHILLATION 1 Yes certificate Division of Vital Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant or Attendation after deat 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) completely filled in by 4 Homicida To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the bast of my knowledge, daeth occurred at the time, data and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Cartifiar Medical (Check only one) 29b. Signatura and titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) P12463 Aug 2, 2000 207002 to 07 30. Nama and addrass of person who completed causa of deeth (Item 23a) (Type, Print) 10. N. GREENE ST. BALTIMORE, MD 21209 BOATENG, MD

DHMH 16 Rev 6/95

Registrar

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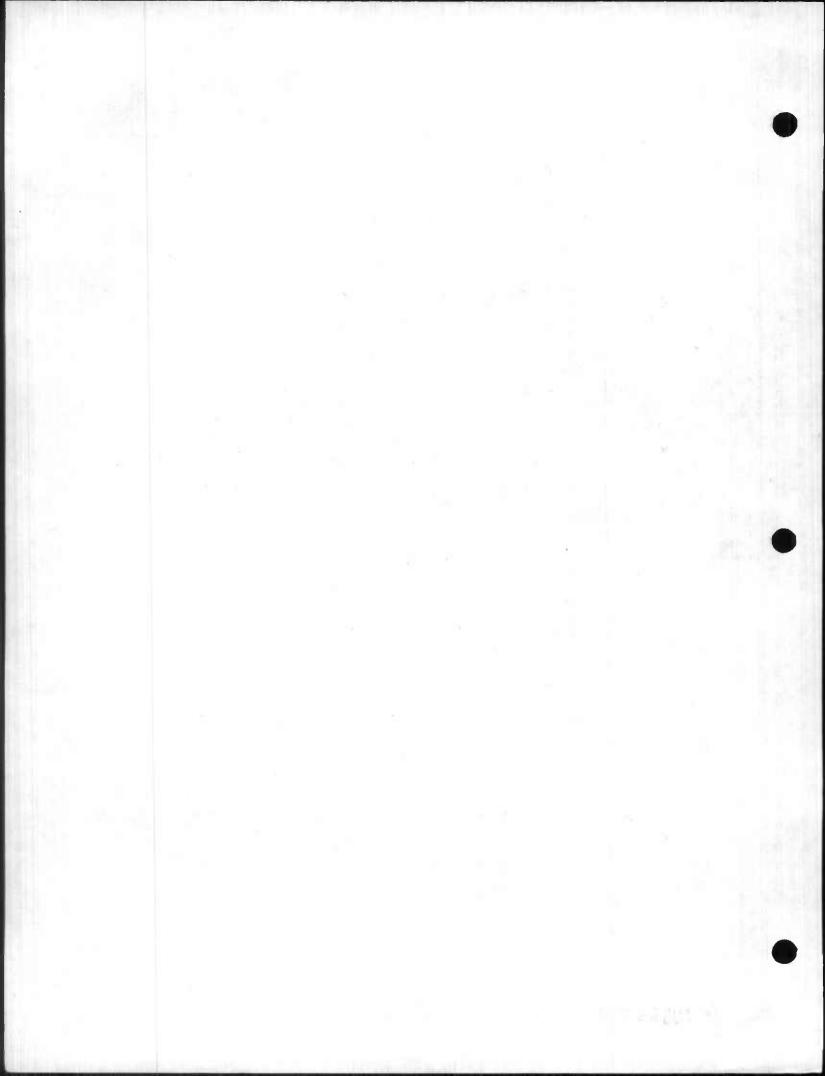
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32. Ragistrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Day **Physician** BOY WIT 01 2000 /Medical 4h City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Deas 3001 Examiner SALTIMUNE PIM CONTOR HANDUBA 1408 MARSON Social Security Number Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 9. 1X M 2 F Days Director Usual Residence of Decedent the Manyland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director laryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harna 23a or Vieu Ve d filed within 72 hours efter death J2. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 6 Baltimore, Maryland 21215-0020 1□ Yes 2No Specify 3 ☐ Widowed 4 ☐ Divorced can "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ai Hygiena. Elementary/Secondary (0-12) College-(1-4or 5+) 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Peges 1 and 2 should be nent of Health end Mental 2 (Sister) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Streat and Number or Flu Stata, Zip Coda) 2 Health Item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other p City or Town, State 20a. Method of Disposition Data 20c. Location -Department of important: If Its any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility Worth Ave. the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each list. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner WHENNA 47 The lew requires that the death certificate be executed es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last Box 68760. the ettending physician Due to (or as a consequence of): pege 2 should be detached for PO Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Be Completed After this certificate has 20 No 2 No 1 Yes 1 Yes aptal or Attending Physicien: The hours after death.
Inersi Director: After this certificate by filled in by the funeral director, pe 25. Was case referred to medicel 26. Placa of Daath (Check only ona) TYPES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) anper of Death 28d. Describe how injury occurred Injury at Work? 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datamined 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 0055700 (Item 23a) Type, HANOVER 8KG BARDAUNG MA

DHMH 16 Rev 6/95

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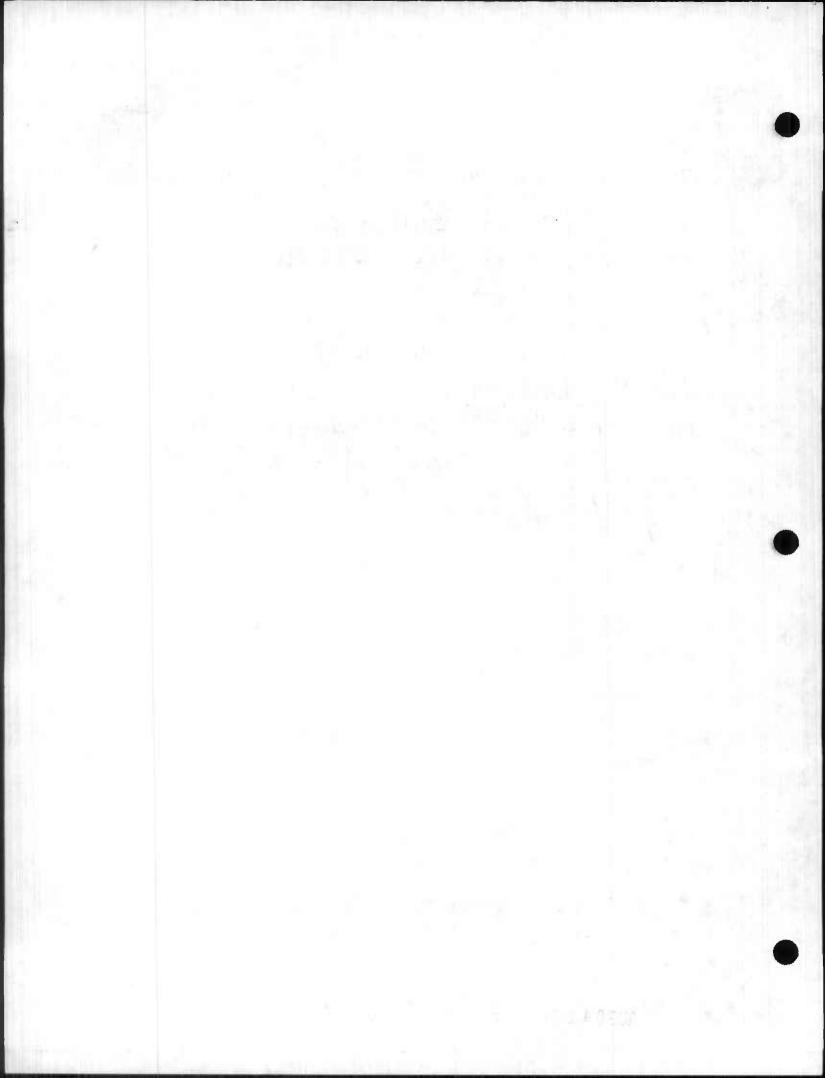
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32. Registrar's Signature



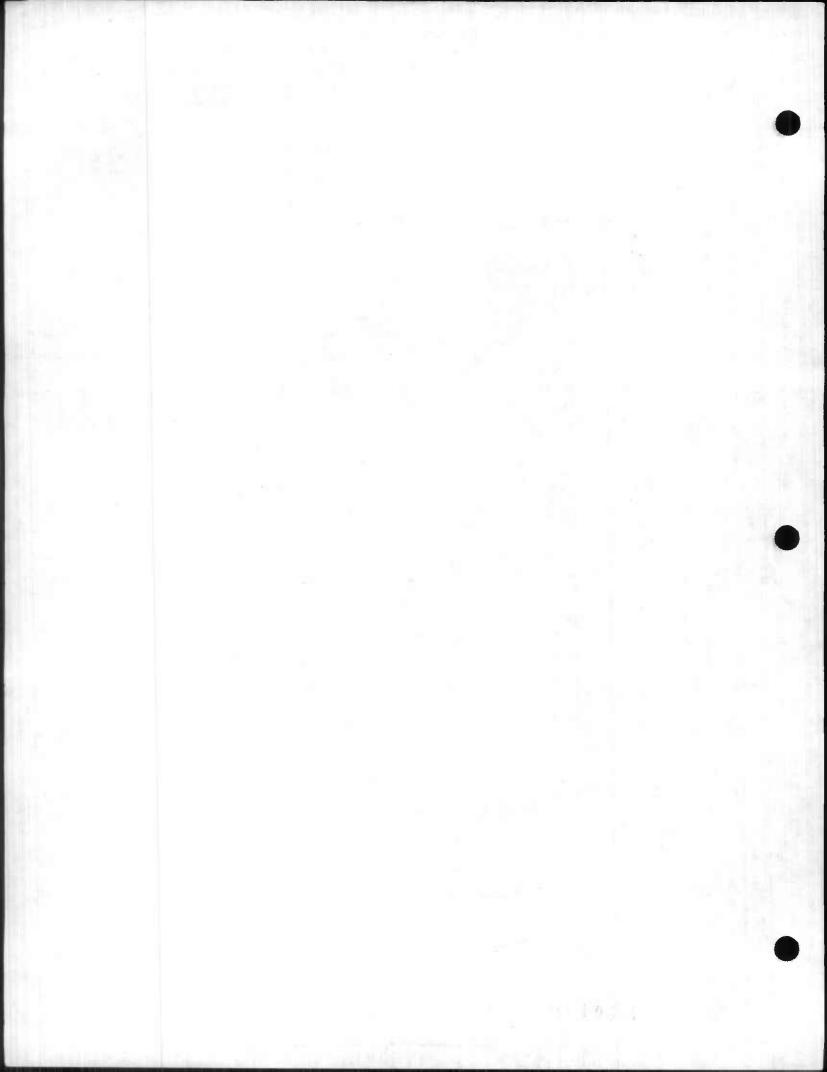
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

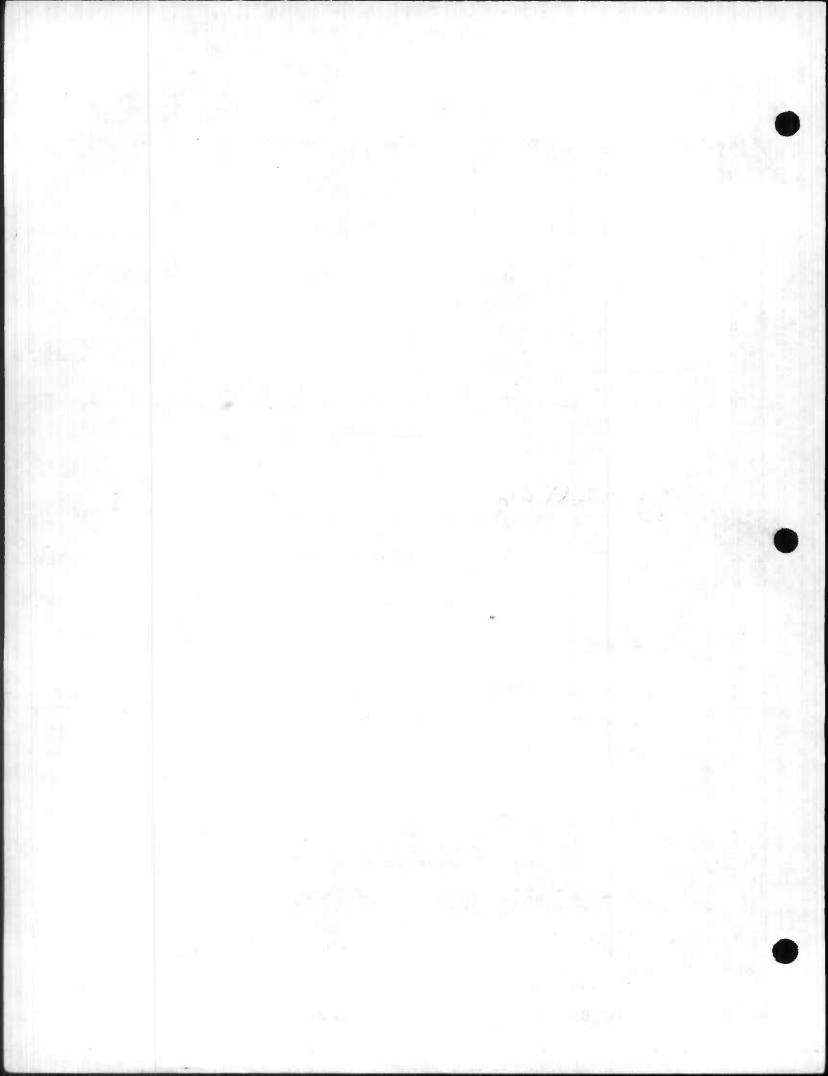
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E	Be ever	17. Father's Name (1	8. Mother's Nam			ne)			
yla	Men Men To To	Ralph Ca	Ivin Morr	ison				Lillian	B. Le	wis				
Maryland	pue de la companya de	19a. Informent'a Na	me/Relationship (T)	pe, Print)	19	9b. Mailing Address	(Street en	d Number or Ru	rai Route Numb	er, City or Town	, Stete, Zip Co.	de)		
100	and 127 er tr	Ethel Ma	arie Morri	son/wife		1425 S	hawa	n Rd.	Cockey	sville.	MD 210)30		
ore	- 五百号	20a. Method of Disp			20b. Place	of Disposition (Nem	ne of	2	/5/00	20c. Location	- City or Town,	Slate		
Ĕ	Page 11 or		☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	temoval from State		green Men				Finksh	ura. N	1D		
Baltimore	and and and and and and and and and and	21, Signature of Fur	110	19 1	7	22. Name and					u. g,			
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	/Medical Examiner	Immediate Cause (I disease or condition resulting in death)		KESPIN	THULL	LHILOKE		E 10			i			
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	To the Total	29b. Signature and					. License			29d. Date sign	ed (Month, Day	r, Year)		
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Day **Physician** Month Year ANDREW MARSHALL 6:10 Am Tul 27 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMERE HOSPITAL CENTER KANDALLSTOWN MORTHWEST | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | Nort Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 220-18-6726 73 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a Stata 10b County 10c. City, Town or Location 10d Insida City Limits 1 Yes 2 No Director Maryland Baltimore notifie Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23s or 3 Mountain Court 21117 Funeral U.S.A. 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) or Berns 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc. 72 hours after 1 2 Yes 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Àq 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Logistics Manager James Gibbons Company 17. Father's Nama (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumema) 86 Emory William Willis Marshall Agnes Krieger 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Cheryl L. McLaughlin - Daughter 5 Old Ring Court; Cockeysville, Maryland 21030 20b. Place of Disposition (Nama of cematery, cremetory or other place) Date 20c. Location - City or Town, Steta 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MD. Vet. Cem. Garrison Forest8/3/00 Owings Mills, MD. 21. Signature of Funeral Service Licensee 22. Nama end Addrass of Facility Loring Byers Funeral Directors, Inc. 80 M00869 8728 Liberty Road, Randallstown, MD 21133 23a. Part Ener the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximata Intarval Between Onset and Death **Physician** Immediata Cause (Finel disease or condition resulting in death) /Medical BOWEL OBSTRUCTION 24 HOURS Examiner Dua to (or as e consequence of): Examiner physician and the burial-transit The lew requires that the deeth certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): 2 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown WING CANGER METASMIL Division of Vitai Records, à CHANNIL GASTAVLTINE PULMONARY DISEASE 24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to Completed completion of causa of death? has 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No or Attending Physician: 8 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yes No this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dala signed (Month, Day, Year) MO 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) FINE . MP JYO) OLD LOURT PLD PANDAUSTOUN MD 21133 COBERT 31. Data filed (Month, Day, Year) 32. Registrar's Signatura AUG 0 4 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** MARY ELLEN MC MANUS 6:00 PM AUG 2000 /Medical 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Marriottsville Howard 2125 Mt. View Rd. /iew Rd.

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min.

8. Dete of Birth (Month, Day, Year) March 25, 1936 5. Sociel Security Number 9. Birthplece (State or Foreign **Funeral** 1□M 2♥F Washington D. C. 220-34-6885 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County "natural", or Items 23a or 28a-f ahow 1 Tyes 2X No ector Maryland Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? D 21104 U.S.A. 2125 Mt. View Rd Funeral 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Meritel Stefus of filed within 72 hours after of Hygiene. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Legal Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be filt Deportment of Health and Mentel Hy important: if them 27 is marked oth any lojury or other treumatic even pace. Be Lee Jennings Wilson Iola Brosenne 19e, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2125 Mt. View Rd. Marriottsville, Maryland 21104 Mr. Robert Emmett McManus Husband 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition Dete Place of Disposition (Name of cemetery, cremetory or other place)

Mt. View Cemetery 1 Burial 2 Cremetion 3 Removel from Stete 08/07/2000 Marriottsville, Maryland 4 ☐ Donetion 5 ☐ Other (Spegfy) 22. Name end Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 a. Pert1. Enter the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fullure. List only one cause on each line. Approximete Intervel Betw Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical · Gun Shot Wound to Head - self inflicted Examiner Due to (or es e consequence of) Examiner months Depression attending physicien and for use es the bunal-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) be axecu Box 68760. Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. the 1 Yee 2√2 No 3 Probably 4 Unknown 2 Records, þ 24b. Were eutopsy findings aveitable prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed 1 Yes 1 Yes 2 No of Vital or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Investigation Injury 1 Neturel self inflicted pistol shot to head ~550 PM 1 Yes 2 No deeth. Aug 2, 2000 after deeth.

Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide home home address as above in 10e To the Hospital or within 24 hours aft. To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and menner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier Deputy 2,2000 ME WY 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

PATRYCE

31. Dete filed (Month, Day, Year) AUG 0 4 2000

A. TO YE

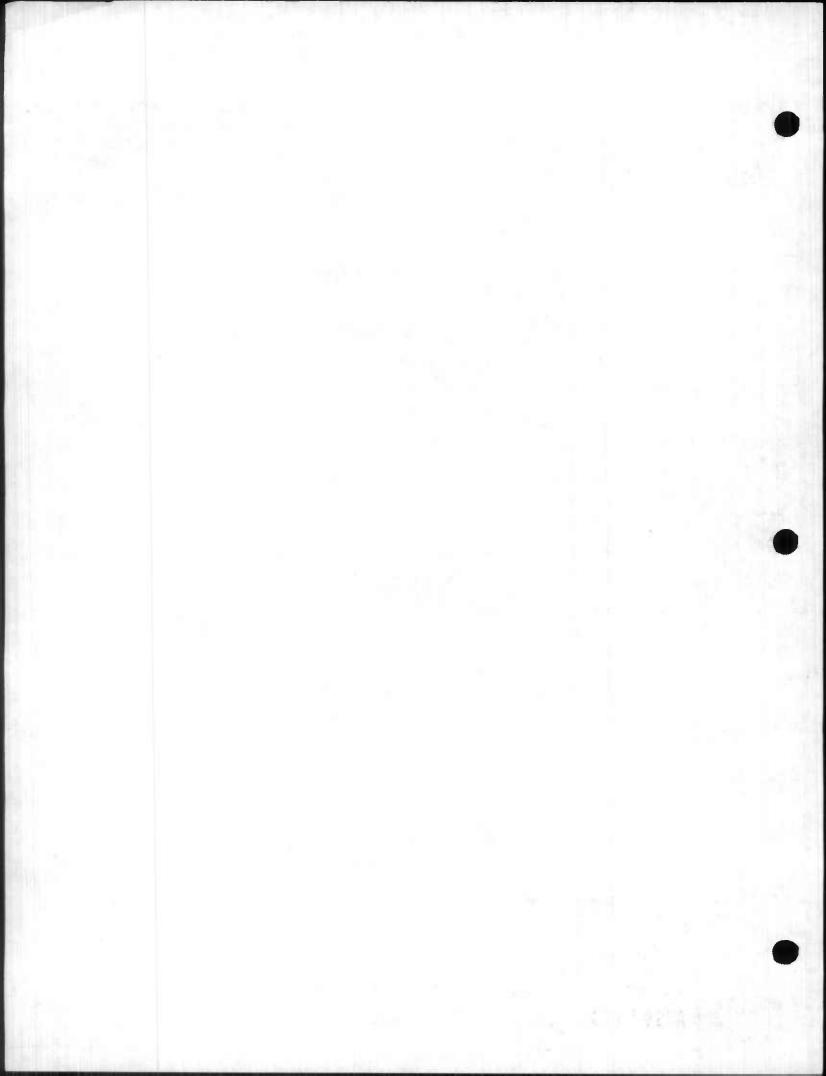
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32. Registrer's Signeture

4565 Hemlock Cone Way Ellicott City MD 21042

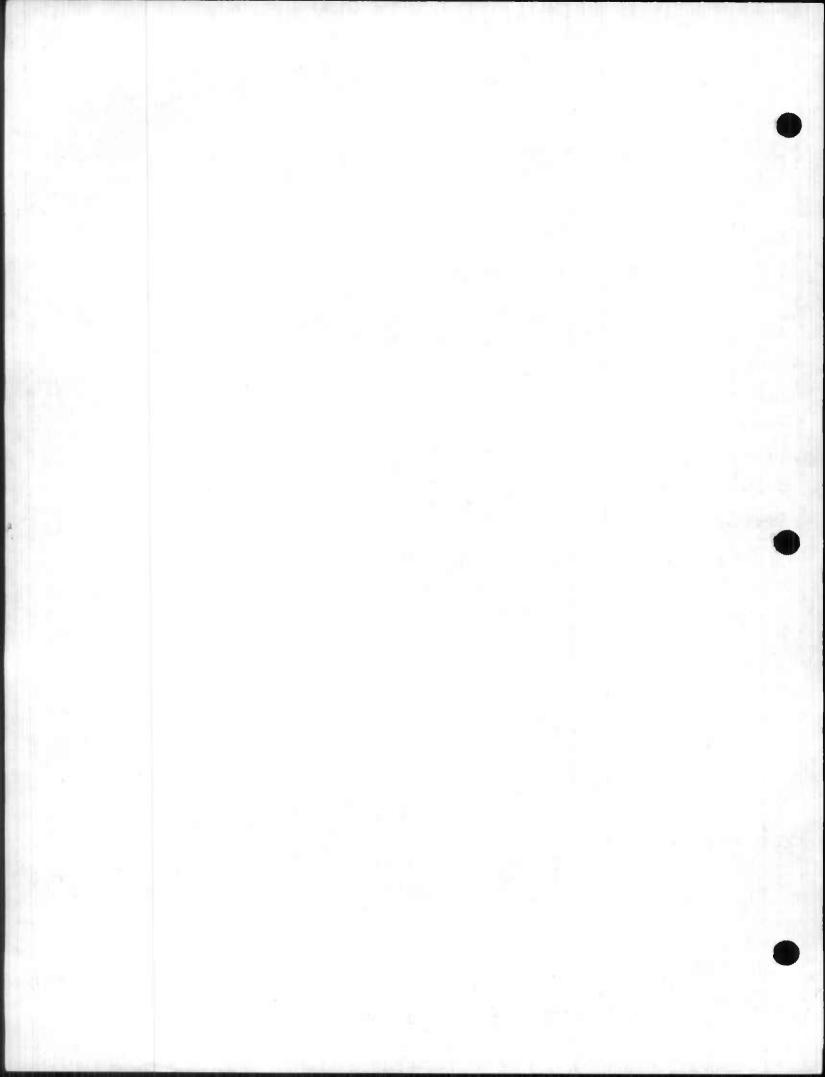
State of Maryland / Department of Health and Mental Hygiene 10 24704

			Ce	rtifica	ite of	Death			Reg. No.	0	. 7 /	04
Discolor	1. Decedent's Neme (First, Middle, L.							2. Dete of De Month	eth Dey	Yeer	3. Time o	Death
Physician /Medical	Dennis Mars	hall Neff										A.M.
Examiner	4e Facility Neme (If not institution, ga	ive street end number)				4b. City, To	wn, or Lo	cation of Deett	4c. County	of Deeth		
	VAMHCS FORT HOWAL	The same of the last of the la					HOMAI			IMORE		-
Funeral			yrs. lest birthday,	Month Month	er 1 Yeer Deys	If Under Hours	Min.	8. Dete of Birt (Month, Da	th y, Year)	9. Birthple Count	ace (State	or Foreign
Director	212-48-3558	₩ ^{M 2□ F} 51	Yrs.					June 2	2,1949	Md.		
3	Usuel Residence of Decedent 10e. Stete 10b. County	10c.	City, Town or Le	ocation						10	d. Inside C	ity Limits
zea-f sho notified at rector	- 71		Dundal									2 No
be notified Director	10e. Street end Number				ip Code				10g. Citizen of V	Vhet Count	ry?	
	32 Township			2	1222				USA			
iner must Funeral	11. Meritei Stetus	12. Wes Decedent Ever i Armed Forces? 1 Yes 2 No	n U,S. 13.	Wes Dec	edent of H	lispenic Ori en, Mexice	igin? (Spe	cify Yes or No Ricen, etc.)	- 14. Rac Bled	e - America k, White, e		
by by		1. Yes 2 □ No If Yes, Give Yeer or Detes:			2 No	Specify:				Whi	te	
r. the Medical	15. Decedent's E (Specify only highest g	Education rade completed)	16e. Dece (Give	dent's Us	vork done	ation during mos	t of worki	ng	16b. Kind of Bu	siness/Ind	ustry	
M di	Elementery/Secondary (0-12)	College (1-4or 5+)							Govern	mont		
	11 Yrs. 17. Fether's Neme (First, Middle, Las	(2)	Mar	ine	Cor		ar's Name	/First Middle	Maiden Sumer		•	
Be ever	Carl V. Neff	n)						L. Bo		,0,		
70	19a. Informent's Neme/Reletionship	(Type Print)	19h Mail	ina Addre	es (Straat				er, City or Town,	State Zin	Codel	
ne pan	Linda Lucas	sister		-					alk Md.			
000	20e. Method of Disposition	Domewaldren State	b. Plece of Disponentery, cre	osition (A	ame of	ce)	A	ug 4	20c. Location -	City or Tov	vn, Stete	
2	4 Donetion 5 Other (Spec		crownsv	rill	e V.	A. C	em		Crownsv	ille	,Md.	
2 8	21. Signature of Funeral Service Lice	insee	2	2. Name	end Addre	ss of Fecili	ty		- f D	2 - 71-		114
58	Alles lon	esp	7	110	Soll	rune ers	Poi	nome	of Dun 21222	аатк		
	23a Pant. Unter the disease, or con	mplication thet caused the d	leeth. Do not en								Approxime Intervel Be	te
ian	and of the art tailule. List only	y one cease on eech line.								1	Onset end	Death
cal	Immediate Ceuse (Final disease or condition	CHRONIC OF	RSTRUCTO	VE P	TTEMON	JARV 1	TCFZ	CE			TARS	
ner	resulting in deeth)	e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or es e consequence of):									TUMO	
je 🚾											MONT	माउ
Examiner	Sequentially list conditions, Due to (or es e consequence of):											AA
	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events sequition in death). Let									i		
edicai	Cause (Disease or injury thet initieted events	C. Due to	o (or es a conse	quence of):							
	resolding in deethy cest	l d.										
detached for use a	Pert II. Other significant conditions	contributing to death but not	resulting in the	ındertving	cause div	en in Pert	1	23b. Did	tobacco uae co	ntribute to	the cause	of death?
hys	ANEMIA	contributing to abatin but not	1030 king in the t	arioonyms	, 02030 giv	011 117 011			Yes 2 No		ably 4□	
by P	AWELLA											
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pege 2 should							_	porte	Jimed :	con	npletion of leath?	cause
Comp	11 - 12 - 1 1 - 1							10	Yes 2 No	1	Yes 2	l No
9 9 S	25. Wes cese referred to medical					26 Diag	n of Donth		**			
irector. per	examiner?	Hospitel: 1 Inpatient		nt 3 🗆 1	Oth	or:		Check only	dence 6 □Oth	as /Canaih		
funeral dire	27. Menner of Deeth	28e. Dete of Injury	2 ER/Outpatie		28c. Injur				how injury occur		,	
tion	1 Natural 5 Pending 2 Accident Investigetic	(Month, Day Yea	r) Injury	М		rk? Yes 2□	No					
Certification:	3 Suicide 6 Could not determine	be one Olean of Injury	At home, ferm, si	treet, fect	orv. office			28f. Location (Street and Numb	er or Rurei	Route Nur	n <i>ber</i> ,
	4 Homicide	building, etc. (Sp	ecity)		.,,			City or To	wn, State)			
completely filled in by the Medical Certifical		hysician: To the best of my										(8)
Sompletely filled in by the Medical Certificat	one)	end manner steted.	THIS CONTRACTOR OF THE	ivostigatii	on, army c	pinion, doi	att1 000011	oo or the tane,				-,
E 2	29b. Signeture end title of certifier	1) 11 711-	* *		9c. Licens				29d. Date signe			
	Heorge C. L	Ville III	$\Pi.D.$		D413	160			July 31	, 200	V	
	30. Neme end eddress of person who	completed ceuse of deeth (Item 23e) (Type	, Print)								
	DR. GEORGE WICKS	. M.D9600	NORTH D	OLVil	BD	FORT	HOUTA	PD MAI	SYLAND 2	1052		
State	31. Dete filed (Month, Dey, Year)	32. Registrer's S				4. 4.4.		1				
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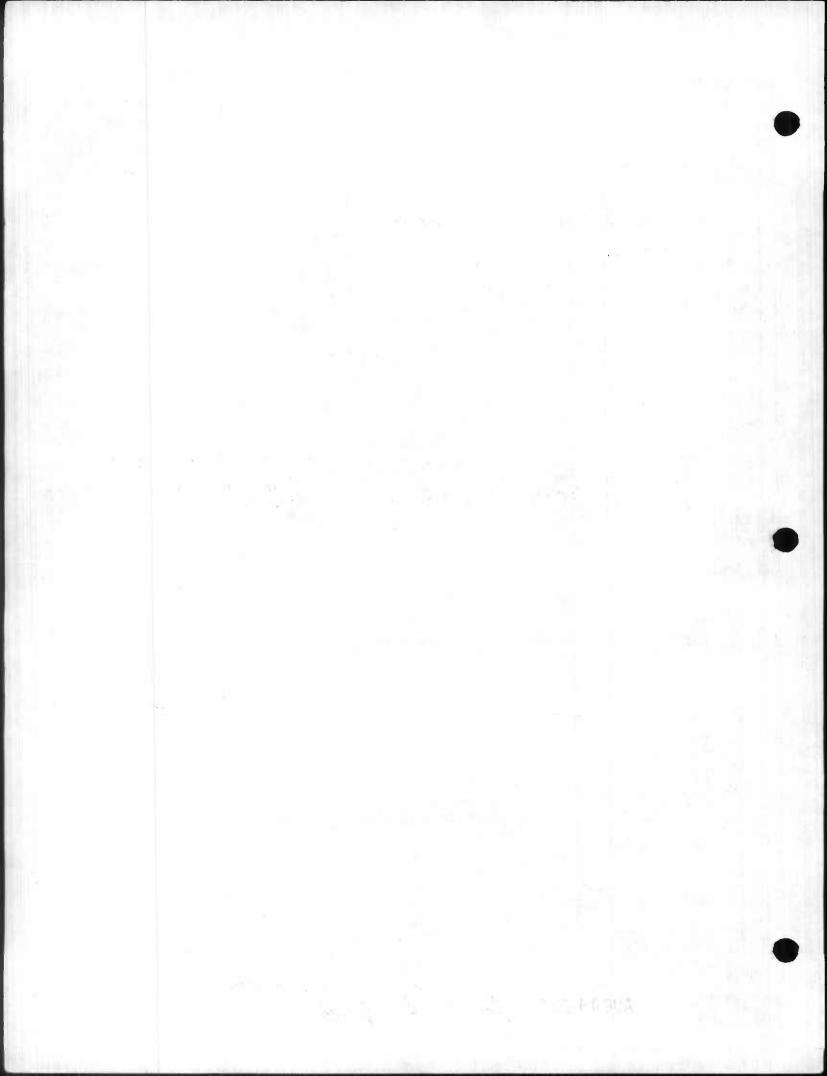
State of Maryland / Department of Health and Mental Hygiene 00 21.705

		Otato of Marylar	Certifica				eg. No.	24/03				
Physician	1. Decedent's Neme (First, Middle, Last)				2. Deta of Dee Month		3. Time of Death				
/Medical	Norma A. Otterbei						3, 2000	7:40 AM				
Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or Lo		4c. County of					
	Augsburg Lutheran 5. Sociel Security Number 6. Sa		fact high days If Linds	ar 1 Yeer	Baltimore If Undar 24 Hrs.		Baltim					
Funeral Director		M 212 F 79	Yrs. Months		Hours Min.	8. Dete of Birth (Month, Dey NOV 27		Birthplaca (Stele or Foreign Country) Maryland				
Mand Mand	10a. Stete 10b. County	10c. Cit	ty, Town or Location	-				10d. inside City Limits				
Many tor	Maryland Baltim	ore B	altimore					1 Yes 2 No				
death with the Maryland me 23s or 28s-f show finant be notified at neral Director	10e. Street and Number 6811 Campfield Ro	ad	10f. Z	ip Code 2120	7	1	0g. Citizen of Who	et Country?				
020 urs after Mr, or to	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:	,S. 13. Was Dac If Yas, sp		lispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yas or No- Rican, etc.)	Black,	American Indian, White, etc. White				
od within 72 ho ygiene. The free free free free free free free fr	15. Decedent's Edu (Specify only highest grad	cation	16e. Decedent's Us	ual Occup	etion duning most of work	ina	16b. Kind of Busin	ness/Industry				
mple mple	Elementery/Secondary (0-12)	College (1-4or 5+)			during most of work			A North Control				
Co. Co.	17. Father's Nema (First, Middla, Last)		Custodiar	1	18. Mother's Nem		Janitoria	aT				
Maryland 212 d 2 should be filed with th and Mental Hygiens. The marked other then traumatic event, the 1 To Be Comp	Caspar Lubertine				Margaret							
Aaryla 2 should I amarke summit:	19e. Intorment's Name/Reletionship (T.	one Print1	19h Meiling Addres	se (Straat	end Number or Run			ele Zio Code)				
Mar and 2 sho baith and n 27 is mer traum	Mary J. Otterbein	ryland 2										
re, N s 1 and t Health tem 27 other tr	20e. Method of Disposition		Place of Disposition (No cemetery, cremetory or			Date	20c. Location - Ci					
Page ento	1 Burial 2 Cremetion 3 1 4 Donetion 5 Other (Specify,	temoval from Stata	k Lawn Ceme			8/5/00 1	Raltimore	e, Maryland				
Baitimore, M permit. Pages 1 and Department of Health Important: If Item 2 any injury or other tr page.	21. Signature of Fineral Service Licens	900	David	J. W	ss of Fecility eber Fune	ral Home	es. P.A.					
	230 Ports Enter the discours by home	speade	401 S.	Che	ster St.	Baltimo	re, Mary	Land 21231				
Physician	23a. Pert1. Enter the disease, or comb shock, or heart tailure. List only of	ne cause on each line.	DO NOT BINE WIE IN	oue or ayn	ig, saun os caraico	or respiretery en	001,	tntervel Between Onset and Death				
Physician /Medical	immediate Cause (Final	RI	TTA	CA	NICEN	LIVIT	71					
Examiner	disease or condition resulting in deeth) Due to (or es e consequence of):											
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68760, rificate be exa physician eas the bunal-ledical Ex	thet initieted events resulting in death) Last	Dua to (c	or es e consequence ot):								
X 6 as AMe		d										
death cert death cert e attendin ed for use												
. 0 0 0	Pert II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	causa giv	en in Pert I.			ibuta to the cause of death?				
E X D	H12HEIH	ELR		101	es 2□No 3	Probably 4 Unknown						
Division of Vital Records, P.O. Box attending Physician: The law requires that the death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use entification: To Be Completed by Physician/Neutlification:						24e. Wes e		24b. Were eutopsy tindings availeble prior to				
The law require tale has been single 2 should Completed						perior		completion of cause of deeth?				
I Re lav						1 🗆 Y	es 202No	1 Yes 2 No				
f Vital Reystian: The law is certificate has director, page 2	25. Was case referred to medical				26. Plece of Deel	h (Check only or	18)					
Of Vita Physician: this certific ral director, I: To Be	exeminer?	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3 [OOA Oth	ner: 42 Nursing Ho	ome 5 Resid	enca 6 Other	(Specify)				
After th funeral	27. Menner of Deeth 12 Neturel 5 □ Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time ot Injury	28c. Inju		28d. Describe h	ow injury occurred					
SIO leath. lor: A the fa	2 Accident investigation 3 Suicide 6 Could not be		М		Yes 2 No	201 1 10		D 1 D 1 Al				
Division of the or Attending P is after death. In Director: After ted in by the funers Certification:	4 Homicide determined	28e. Pleca of Injury - At h building, etc. (Special	ome, ferm, street, fectory)	ory, office		City or Tow		or Rurel Route Number,				
Division To the Hospital or Attending I within 24 hours after decident. To the Funeral Director: After completely filled in by the funeral Medical Certification	(Check only 2 Medical Exam	sician: To the best of my kno ner: On the basis of exemine	owledge, deeth occurre	d et the ti	me, dete end plece,	end due to the o	euse(s) end meni late end plece, en	ner as stated. d due to the cause(s)				
the thin 2 the mple	29b. Signature and title of certifier	end menner steted.	10	9c Licans	se number		9d Date finned	Month Day Year)				
F3 F8	255. Signature Brid title of Certifier		1	3819C-		29d. Date/signed (Month, Dey, Year)						
10	Vasueur	Xallean	00-147	200	701 17		14700					
Ch	TASNEEM (ompleted cause of deeth (Iter	72 20 /	ARK	HEIGH	tri A	E, BA	tero MD 2120				
State Registrar												



State of Maryland / Department of Health and Mental Hygiene 0 2470

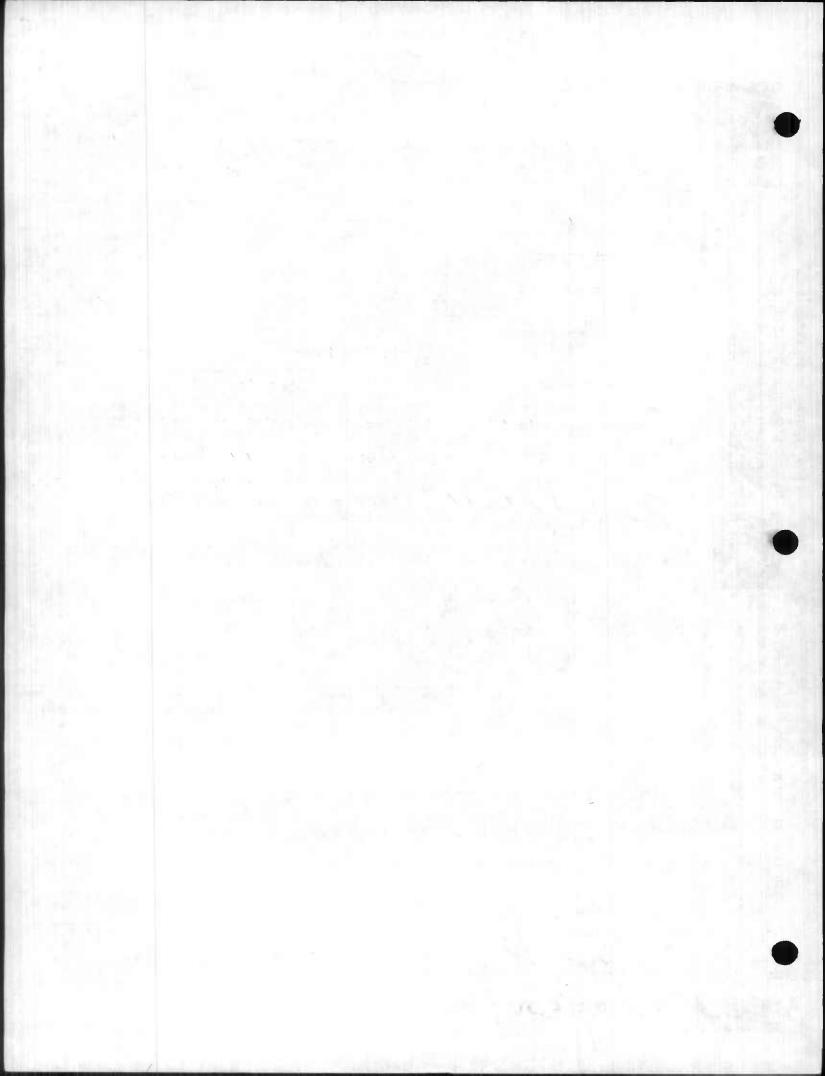
			Certifica	te of Death	R		24/00						
Physician	1. Decedent's Name (First, Middle, Last)				2. Dete of Dee Month		3. Time of Death						
/Medical	DOROTHY ALICE	OSTROWSKI			July	26 2000	2:55PM						
Examiner	4a Facility Name (If not institution, give Future Care Canton Ha			Baltimo		N/A	th						
Funeral Director		7. Age (In yrs.	. last birthday) If Under Months	or 1 Year If Under 24 Hrs Days Hours Min		9. Bird 1923 Ving	iuntry)						
pue *	Usual Residence of Decedent 10a. Stete 10b. County	10c. Ci	ity, Town or Location			10d. Inside City Limits							
the Maryler 28a-f ehow notified at	Maryland Baltimore	Pik	kesville										
far death with the Maryland r terms 23s or 28s-f show the must be notified at Funeral Director	10e. Street and Number 207 Oak Avenue			p Code 208	1	0g. Citizen of Whet Co USA	untry?						
urs after ur, or he merche by Fur	11. Marital Status 1 Never Married 2 Merried	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 272 No If Yes, Give Year or Detes:	se? If Yes, specify Cuban, Mexican, Puèrio Rican, etc.) Bleck, Wh 1 ☐ Yes 2XXNo Specify: Specify:										
"natural" natural	15. Decedent's Educ (Specify only highest grade	cation e completed)	18a. Decedent's Use	ork done during most of wo	orkina	16b. Kind of Business/	Industry						
	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		Dey 260 2000 2:55PM 4c. County of Deeth N/A th Year)							
Hygle district	10 17. Father's Name (First, Middle, Last)		I Home	maker	me (First Middle I								
should be filed v and Mental Hygle warked other t urmatic event, the To Be Co	Unknown	Dr	oley		Jnknown	naroon oumano,							
2 should and Mountain	19a. Informent's Neme/Reletionship (Ty)		7		All the state of the	Route Number, City or Town, State, Zip Code)							
and 2 alth a 27 le	Patricia A. Wiatrowski	20e Method of Disposition 20b Place of Disposition (Name of Date 20c Location - City of Disposition (Name of Disposition (Name of Disposition - City of Di											
permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, the Motica. To Be Comp	20e. Method of Disposition 1XXBuriel 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	emovel from State	Plece of Disposition (Na cometery, crematory or Air Memorial	other place)									
permit. Peges Depertment of I Important: If its eny Injury or of page.	21. Sgneture of Funeral Septice Licenses 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Hon 6500 York Road Baltimore, Maryland 21212												
Physician		cations that caused the dealer cause on each line.	th. Do not enter the mo	de of dying, such es cardia	ac or respiretory err	est,	Intervel Between						
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) a. CMACI MOM A OF CALL BLADDER Due to (or es a consequence of):												
death certificate be assected attending physician and of or use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (d	or as a consequence of										
E 0.6	that initiated events resulting in death) Lest Due to (or es a consequence of): d												
	Pert II. Other eignificant conditions con	23b. Dld to	bacco use contribute	to the cause of deat									
requires that the death cereen signed by the attendir hould be deteched for use etect by Physician/A	DEMENTIA				1 U Y	2 No 3 ₽	robably 4 Unkno						
ew requests been 2 shoul						ned?	eveilable prior to completion of cause						
The page					1 🗆 Y	s 2DNo	1 ☐ Yes 2 ☐ No						
Physiclen: The law this certificate has ral director, page 2 TO Be Comp	25. Wes case referred to medical examiner?	la anitali			eth (Check only or	e)							
	1 Yes 2 No	lospitel: 1 Inpatient 2			1		city)						
Attending F or death. ector: After by the funer iffication:	1 Neturel 5 Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe no	ow injury occurred							
	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fecto fy)	ry, office	28f. Location (St City or Town	reet and Number or Ri n, Stete)	ural Route Number,						
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29e. Certifier 12 Certifying Physics (Check only one) 12 Medical Examination	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, deeth occurred ation and/or investigation	at the time, dete end place, in my opinion, deeth occ	e, and due to the coursed at the time, d	ause(s) end menner as ate end place, end due	s stated. a to the cause(s)						
within To the comp	29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month,												
	4) 61	10		247945		July 27, 200	0						
7	30. Name end eddress of person who co Haris Aleam MD 91(imore, Marvland	21237								
State Registrar	31. Dete filed (MAUG*0*4") 200(32. Registrer's Signa		all									



State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Re	ng. No.	0 24101	
	Decedent's Neme (First, Middle, Last)	2. Dete of Deeth	h Dev	Yeer 017 4 4	
Physicia /Medic	('acimir &' Diacowicz	August	1,20	00 811 AM	
Examine	4a English Name (Mant in etitution give street and pumber)	Location of Death	4c. County	of Deeth	
	Maryland Freneral Luxpital Bultmon	RE CTYY	B Auto	N/A	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Deys Hours Min.		Year)	Birthplace (State or Foreign Country)	
Director	025-01-9880 X X X X X X X X X X X X X X X X X X	April 2,	1915	Massachusetts	
D .	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
ahow				1 [™] Yes 2□No	
the Maryle 28s-f shorn notified at	Md. N/A Baltimore City 10e. Street and Number 10f. Zip Code				
A A	10e. Street and Number 10f. Zip Code		Og. Citizen of V		
death with the Maryland ms 23a or 28a-f show creat be notified at	1919 Park Avenue 21217		U.S.A.		
	1919 Park Avenue 22217 11. Meritel Stetus 12. Wes Decedent Ever In U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puerl It Yes 2 □ No	to Rican, etc.)		a - American Indian, k, White, etc.	
	1 Never Married 2 Married 1 Yes 2 No H Yes, Give 1 Yes of Detes: WWII 1 Yes 2 No Specify:		Specify	White	
72 hours effer "natural", or fa			16h Kind of Bu	siness/Industry	
n 72	(Specify only highest grede completed) (Give kind of work done during most of work	rking	TOD. KING OF DO	on to sain dustry	
withir than	Elementary/Secondary (0-12) College (1-4or 5+) 4 Chemical Engineer		esearch	n & Developemen	
Hygid Hygid Hher Hher	17. Father's Neme (First, Middle, Last) 18. Mothar's Ne/	me (First, Middle, N	Aaiden Surnam	a)	
d be sed of be s	17. Father's Neme (First, Middle, Last) Waslaw Plasewicz 18. Mothar's New Vero	nica Beki	.esz		
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and 2 saith ar 27 le	Mrs. Dolores Plasewicz/Wife 1919 Park Avenue Bal				
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		owson, Ma			
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Examiner	Immediate Couse (Final disease or condition resulting in death) a. Atheroscience (and out	K3CMIW	017	- CUSC	
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Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I.			ntribute to the cause of death?	
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sign Id be		24e. Wes er	n autopsy	24b. Wera autopsy findings	
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ysician: The I is certificate hi director, page	examiner?	ath (Check only on	e)		
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or Attending Physician: The law requires the ster death. Director: After this certificate has been signe tin by the funeral director, page 2 should be come.	2 Accident Investigation 3 Suicide 6 Could not be	28t Location (St	treet and Numb	per or Rural Route Number,	
or At offer Olrec in by	28a. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)	City or Town		er or nural noute (vulliper,	
S To D	27. Mennerof Deeth 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28a. Placa of Injury - At home, ferm, street, factory, offica 28a. Placa of Injury - At home, ferm, street, factory, offica 29e. Certifler (Check only one) 29e. Certifler (Check only one) 29e. Medical Examiner: On the best of my knowledge, deeth occurred et the time, date and place of the content				
To the Hospital within 24 hours to the Funeral completely filled	29e. Certifier (Check only one) 29 Medical Examiner: On the best of my knowledge, deeth occurred et the time, date and place (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred and manner steled				
To the nosptul or attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	end manner steled. 29c. License number	2	9d. Date signe	d (Month, Day, Year)	
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+1	129 pt 1403		0/01/0	20	
}	30. Neme and address of berson who completed cause of death (Item 23a) (Type, Print)	000	1/22	40	
2	Liagat Mei, 11.10, 40, 11 laky Jang Gerel	each 1	Mark	ine	
Stat	31. Dete filed (Month, Dex Near) 1 200032. Registrates Signature				

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#25 PER MD. G786 8-30-2000 JAB Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Par Ver James 0200 2010) 4 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death oward 15 onuty Gen If Undar 1 Yaar Months Days If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth Birthplaca (State or Foreign Country) Days 1 M 2 F 57842-3266 Yrs. 64 08/23/1935 Washington, D.C. Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 🏋 ☐ No Maryland Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4725 Homer Avenue 20747 U.S.A. 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Bleck, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 1 ☐ Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Valet 11 Refinish Shoes 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) James Parker Sr. Beatrice Tucker 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Parker / Brother 425 2nd. Street N.W., Washington D.C. 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Bunal 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 08/04/00 Baltimore, Maryland Metro Crematory 21. Signatura of Funeral Service Lic 22. Nama and Addrass of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 mplications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, or implications that cause List only ona causa on aach Approximate Intervel Betw Onsat and Death Immediata Causa (Final disaasa or condition resulting in daath) 7 8 CM CM CM 9 Dua to (or as e consequence of) Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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page 2

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To the Funeral Director: A
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Completed by

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Certification: To

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3 Suicida

29a. Cartifier

4 Homicide

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

the Hospital or Attending Physician:

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death.

Physician

/Medical

Examiner

10a. State

Funeral

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examins, main be notified at

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death

permit. Peges 1 and 2 should be filed within 72 hours effer d Department of Haalth and Mantel Hygiane. Important: If frem 27 is merked other than "netural" any injury or other traumatic events.

Examiner Sequentially list conditions, if any, leading to immadiata ceuse. Enter Undarfying Ceuse (Disaasa or injury that initieted avants rasulting in daath) Last Physician/Medicai

24a. Was an autopsy performed? 1 ☐ Yas 25. Was cesa referred to medical exeminar? 26. Placa of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1X Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Tima of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant

24b. Wara autopsy findings available prior to completion of cause of death?

2 NO

1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 1 Certifying Physicien: To the bast of my knowledge, daath occurred at the time, dete end place, and dua to tha cause(s) end mannar es stated.

2 Medical Exeminer: On the bast of examinetion and/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the ceusa(s) and mannar stated.

(Check only one) 29b. Signatore and titla of certifiar

6 Could not be

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Name end addrass of person who co stad ceuse of deeth (Item 23a) (Type, Print) K92/06 69x4

Ors Ridge Rd Chansiz MOTOYS

State Registrar 31. Data filed (Month, Day, Year) AUG 0 4 2000

32. Ragistrar's Signal

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Flossie Pumphery 31,2000 5:37 A.M July 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Richey Hospice Baltimore City If Under 1 Year If Under 24 Hrs. Hours Min, 8. Date of Birth (Month, Day, Y 10/23/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 M 2 TF 68 219-28-5236 Baltimore, Md Usuet Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d Inside City Limits 1 X Yes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 400 Millington Ave. 21217 USA Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Raca - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2X No 1 ☐ Yes X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Pumphery ESther Pumphery 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 W. Lombard Street, Zanita Williams Baltimore, Md. 21216 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Stata Zion Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Mt. 8/4/00 Lansdrown, Md. 21. Signature of Funeral Servica Licansee Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217 23a. Part1. Enter the cheese, of complice ons thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilura. List only one ceuse on each line. Approximete Intervet Between Onset and Death Caremonia 18445 Immediete Cause (Final disaese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Doknown 1 | Yes 2 | No 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Spice Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending

Examiner physicien and the burial-transit à certificata Division of Vital Attending Physicien: Director: ծ To the Hospital of within 24 hours at To the Funerel D

Physician

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r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

filed within Hygiena.

permit. Pages i and 2 should be filed will Department of Health and Mantel Hygiens Important: If Item 27 is marked other than any injury or other treumatic event, that once.

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Medical Certification: To

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Baltimore, Maryland 21215-0020

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25. Was case referred to medical 1 Yes 2 No 27. Mennes of Deeth

2 Accident

3 Suicide

29a. Certifier

4 Homicide

investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

(Check only one) 29b. Signature and 6tie of certifie

29c. License number

29d. Dete signed (Month, Dey, Year)

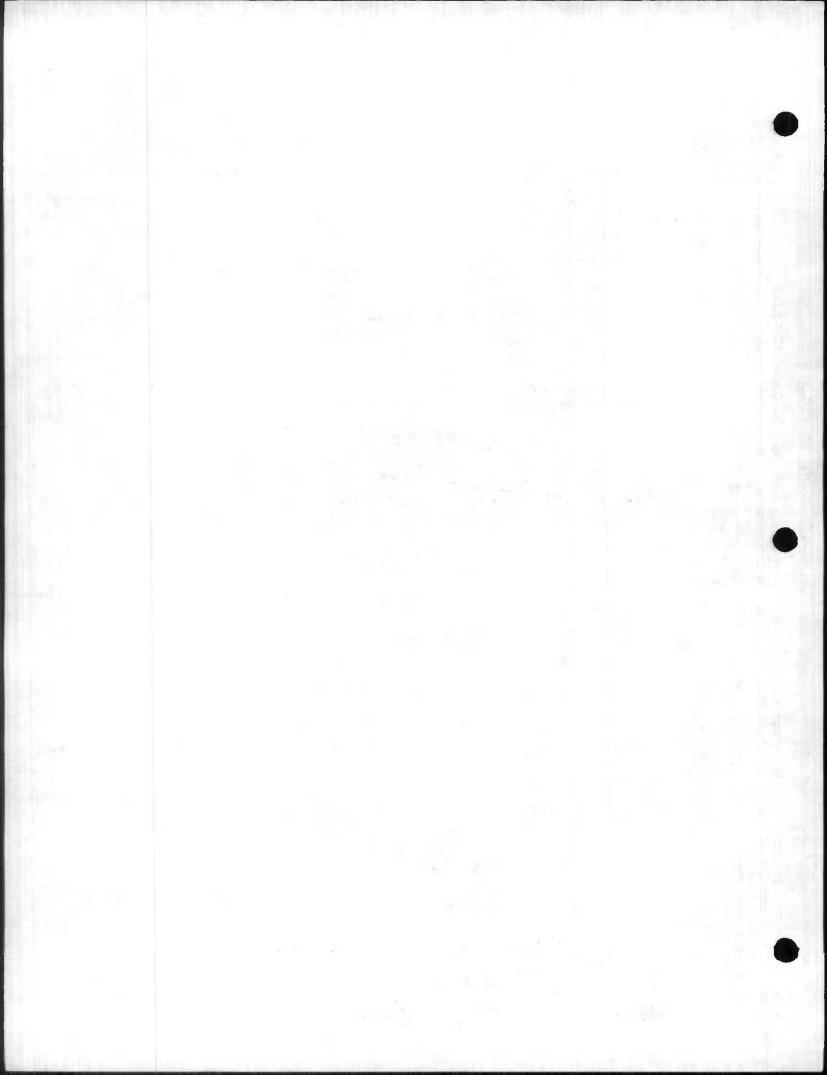
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 838 N. EUtaw St. PSa / to Mario LTWIN del KODOX

31. Dete filed (Month, Dey, Year) AUG 0 4 2000

32. Registrer's Signature

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Registrar DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

								Cei	tificate	of	Death		,	Reg. No.	U	24/10
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	V)		30. Name and addr G. M. WE	ess of person	who completed .D., M.P.I	ause of d	eath (Item	23a) (Туре, Етт	Print)	/ *	COAD.	AB	INGDO	N, MD	21	009
	Sta Registr	_	31. Date filed (Mon	th, Day, Year)			ar's Signat		de	nou	6					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 30% 2000 Kenneth 0. Pridaet 7:30am 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1□M 2□F 214-02-5782 34 01-15-66 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits MD NA Baltimore XIX Yes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 512 Winston Avenue 21212 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 Yes 2€ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntary/Secondary (0-12) College (1-4or 5+) 10th Grade NA Laborer various jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pridget Lester R. Mildred Higgs 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Mildred Knights 3605 Monterey Road Apt. #B Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) King Mem. Pk. Cem. 08-03-2000 Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee emond nountly WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on your cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final H. I.V. DISEASE EARS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown OCCUPYING CEREBRAL LESION 24b. Were autopsy findings aveilable prior to 24a. Was an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No

Examiner physician and the burial-transit Box 68760 an/Medical attending pl P.O. 1 signed by the a d be detached fi Records, certificate of Vital director, this funeral Certification: Division After he Hospital or Attending in 24 hours after death. he Funerel Director: Afte pletaly filled in by the fun

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Hadical Examiner must be notified at

it of Health and Mentel Hygiene. If Item 27 Is marked other than

permit. Peges 1 and 2 sh Department of Health end Important: If item 27 ie m eny injury or other treum pace.

Physician /Medical

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Physic by Completed 8

3 Suicide 4 Homicide 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one)

27. Manner of Death 1 19 Netural 2 Accident

6 Could not be

Suractohi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number 006933

29d. Date signed (Month, Day, Year) JULY 318 2000

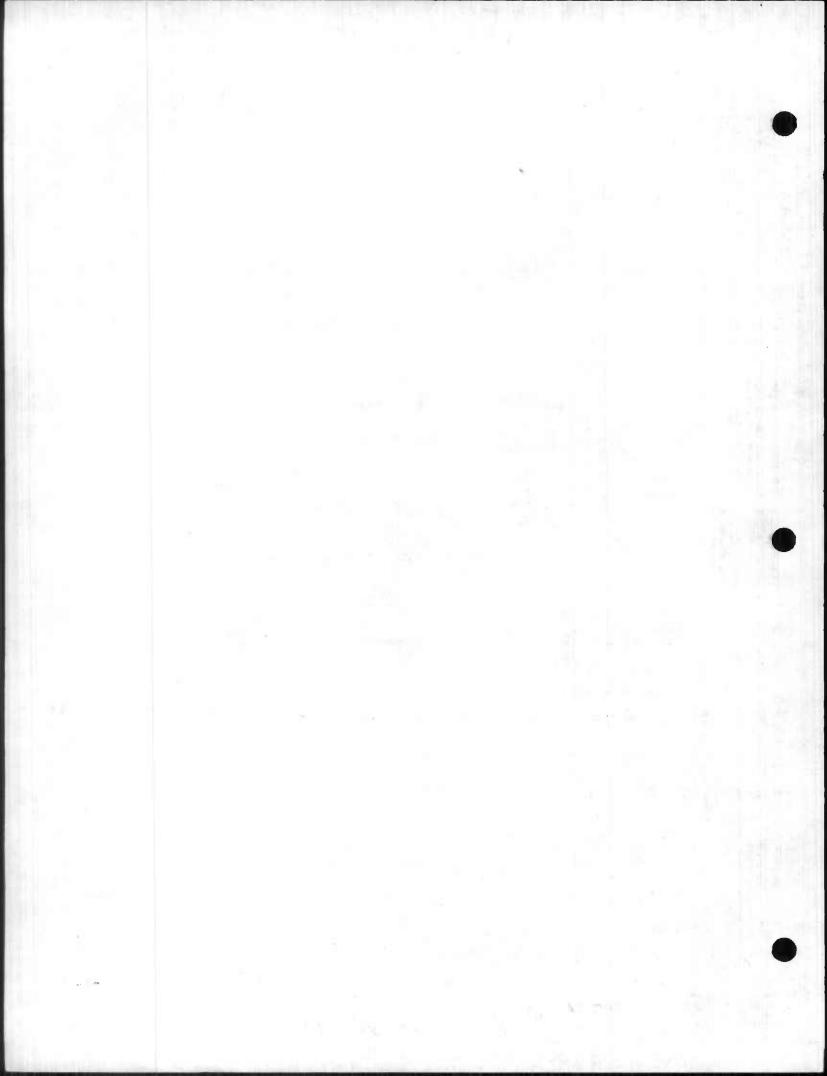
State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) AUG 0 4 2000

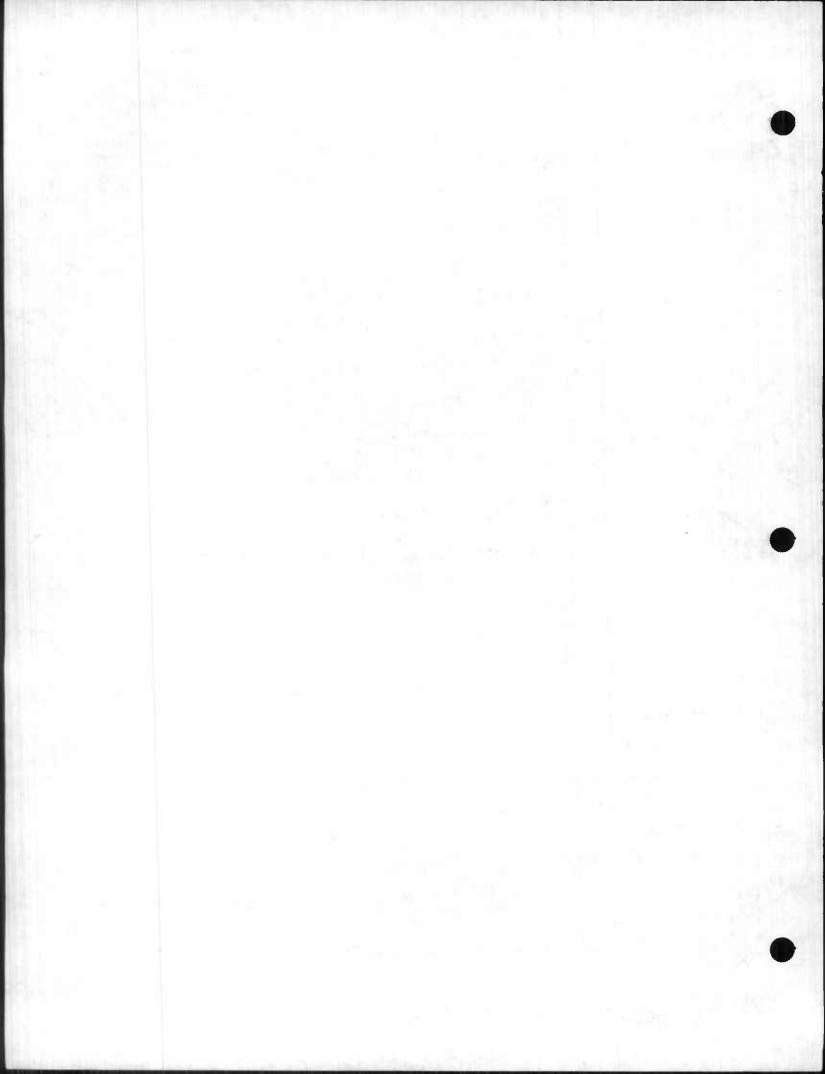
YOHN B MACGIBBON 300 ARMORY PLACE SUITE 3G BALTIMORE MO 21201 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylar	Certifica				Reg. No.	24712					
Physician	1. Decedent's Name (First, Middle, Las	hodes		4.	City Town 22 2	2. Date of De Month Tuly	28 20						
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Director	Usual Residence of Decedent 10a. Stete 10b. County	6/	ity, Town or Location			MAY /	2,1933	N.C.					
and at the store	MD Baltimor		dalk					1 □ Yes 2 N					
a or 28a-f s the notified	10a. Street and Number 55 Northship Roa		10f. Z	ip Code			10g. Citizen of W	hat Country?					
saminer met saminer met by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1/	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No Rican, etc.)	USA 14. Race Black Specify:	- American Indian, k, White, etc.					
d other than 'nature overst, the Medical E event, the Medical E Be Completed 1		ucation	16a. Decedent's Us (Give kind of w life. DO NOT Carpente	ork done duni use retired)	n ng most of workir	og .	16b. Kind of But						
event,	17. Fether's Neme (First, Middle, Last)		ourpence	18. Mother's Name (First, Middle, Maiden Surname)									
To	Nathan B. Rhodes 19a. Informant's Name/Relationship (7	ivpe, Print)	19b. Mailing Addre		Celly Ha	-	er, City or Town,	State, Zip Code)					
a 27 is ar trau	Brenda Liptrap	Daughter	55 Norths	ship Ro	p Road Dundalk MD 21222								
ary or oth	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemovai from State	Place of Disposition (Nocemetery, crematory or esapeake C1		y 8,	Date /1/00		City or Town, State					
amy inju	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, MD 21222 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate												
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has mp	Artie Augun			-				completion of cause of death?					
# 0 O	25. Was case referred to medical	evi		2	6. Place of Death		Yes 2 No	1 ☐ Yes 2 ☐ No					
frer this uneral di On: To	27. Manne of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?			idence 6 DOthe how injury occurr						
within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, factority)	ory, office			tion (Street and Number or Rural Route Number, or Town, State)						
in 24 hour he Funera pletely fill edical		rsicien: To the best of my known of the basis of examination and manner stated.											
To the comp	29b. Signature and title of cerules			(Month, Dey, Year)									
4	30. Name and address of parson who co	ompleted cause of death (Ite		21960		~	W7-2	9-2000,					
State Registrar	31. Date filed (Month, Day, Fear) AUG 0 4 2000	Seperate Sign		lover .	street	Sach	ive , No	refleed 21230					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month Dev CHARD ROBERTS 1:40 AM 2000 AUGUST 2, 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WILSON HEALTH CARE GAITHERSBURG MONTGOMERY If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Deys Hours 10M F Months 89 Yrs MARYLAND 225-84-1432 Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 20X No MARYLAND MONTGOMERY GAITHERSBURG 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 401 RUSSELL AVENUE 20877 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) HENRY D. COOK SARAH CHARD 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 33761 19e. Informent's Neme/Reletionship (Type, Print) (SON) 3074 EAGLES LANDING CIRCLE, WEST, CLEARWATER, FL. MR. DONALD R. ROBERTS, JR. 08/05/2000 Location - City or Town, State 20b. Place of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State CHESAPEAKE CREMATION CENTER, LLC, STEVENSVILLE, MD. 5 Other (Specify) 4 Donation 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., T SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 100795 of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Finel diseesa or condition resulting in deeth) oardia J.30 Dua to (or as e consequence of) can onar a Sequantielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disaase or injury that initieted evants resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of geath? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axeminer? 26. Place of Death (Check only ona) Other: 4 Nursing Home '5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28e. Deta of Injury (Month, Dev Year) 28b Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed ician and burial-trans Box 68760, 98 signed by the a P.O. Records, should page 2 After this certificate Division of Vitai Attending Physician: director. funeral death. after death 6

Physician

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Baltimore, Maryland 21215-0020

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State Registrar

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31. Date filed (Month, Day, Year) AUG 0 4 2000

29c. License number

Gaithersburg Md

1 🗹 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, end dua to tha causa(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and moner steted.

29d. Date signed (Month, Dev. Year)

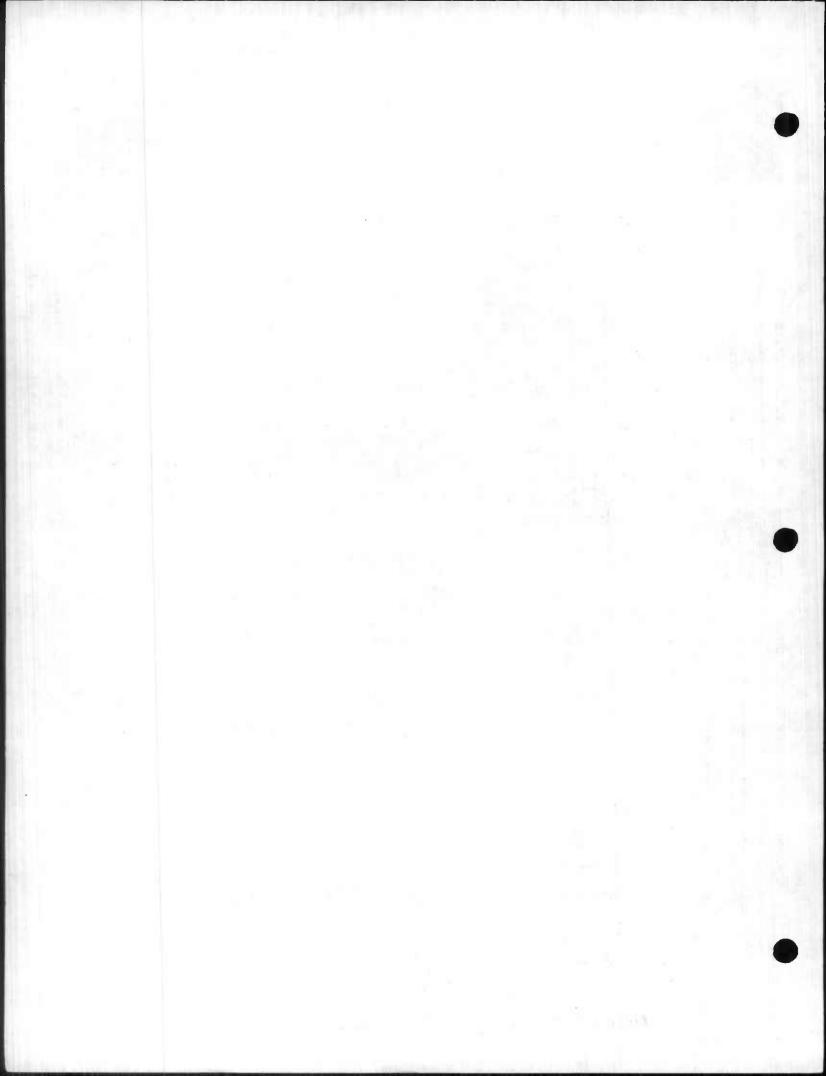
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30. Name end eddress of person who completed cause of deeth (Item 2.) (Type, Print)

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32 Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtifica	te of	Death			Reg. No.		- Y	1 1 7
Physicial /Medica	n I		Ric							2. Date of D Month AUG	Day 1 St	Year OO		of Death
Examine	4a Facility Name	(11 not institution, give			edical		em	Ba	1tin	ocation of Dear				
Funeral Director	5. Social Security	3827	Sex XDM 2□F	7. Age (In yrs. 49	last birthday) Yrs.	Month.	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Year) 1950 Birthplace (State or Country) Mass.				
with the Maryland a or 28a-f show be notified at	Usual Residence of 10a. State Md.	10b. County Balti	more		y, Town or Lo									e City Limits
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020 um after dos af, or flams Examiner m	11. Marital Status 1 Never Mar 3 Widowed	ried 200 Married	12. Was Dec Armed Fo 12 Yes If Yas, Gi Year or D	2 □ No			edent of H ecify Cuba 2 No	lispanic Ori an, Mexicar Specify:		ecify Yes or N Rican, etc.)		Race - Ameri Black, White ecity: Whi	etc.	1.
21215-0020 d within 72 hours al giene. er than 'natural', or the Medical Exam		15. Decedent's E acity only highest gra			16a. Dece (Give	kind of v	ual Occup rork done	durina mos	t of worki	ing	16b. Kind o	of Business/Ir	ndustry	
212 d with	Elementary/Sec 11 yı		College (1-4or 5+)		oren		-,			Crane	e Ope	rato	r
	17. Father's Name	(First, Middle, Last H. Ric								M. La				
Mary and 2 sho allth and 1 27 is me or traume		Rice	Type, Print) Wife							t Rd.	-			21219
Pages 1.	1 🗙 Burial 2	20a. Method of Disposition 1 \(\mathbb{Z}\) Burial 2 \(\mathbb{C}\) Cramation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{D}\) Other (Specify) 20b. Place of Disposition (Name of cemetery, cramatory or other place) Oak Lawn Cem. Date Aug. 8 20c. Location - City or cemetery, cramatory or other place) Baltimon												
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cords, P.O. Box 68760, requires that the death certificate be assecuted seen signed by the attending physician and hould be detached for use as the bunal-transit.	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):													
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r Attendent free death free death free form	2 Accident 3 Suicide 4 Homicide	investigatio 6 Could not be determined	e 28a. Place	of Injury - At ho ng, etc. (Specif	oma, farm, sti					28f. Location City or To	(Street and Nown, Stata)	umber or Ru	ral Route I	Number,
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To the To the comp	29b. Signature and	d titla of certifier	izi N	10		2	9c. Licens	52	065	4		gned (Month	-	
4	30. Name and add	ress of person who	complated caus	e of death (Item	n 23a) (Type,	Print)					RYLAND	L mea	l'cal:	system.
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State of Maryland / Department of Health and Mental Hygiene 00 24715

	Certificate of Death	F	Reg. No.	24110		
Physician	1. Decedent's Neme (First, Middle, Last) Bernice J. Rubley	2. Dete of Dee Month August	Dey Year	3. Time of Deet		
/Medical Examiner	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or L.		4c. County of Dee			
Examiner	Anne Arundel Medical Center Annapoli	S	Anne Arundel			
Funeral Director	5. Sociel Security Number 430-50-9984 6. Sex 1 Months Days Hours Min.		9. Bir	thplece (Stete or For		
Director	Usual Residence of Decedent	Juli //	2300 1120	- Country		
ð u	10a. Stafe 10b. County 10c. City, Town or Location			10d. inside City Li		
a or 28s-t show the notified at	FL Hillsborough Tampa			1 ☐ Yes 2 🕅		
or 28s-1 s be notified	10e. Streef end Number 10f. Zip Code	1	10g. Citizen of What Co	ountry?		
23a o unt be	11217 Bloomington Drive 33635		USA			
ibers 23s iber.must Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (State of the specify Cuban, Mexican, Puertone)	pacify Yes or No-				
by by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	o Rican, etc.)	Black, Whit	white		
ypiene. Nr. the Medical. Completed	15. Decedent's Education 16a. Decedent's Usuel Occupation	16b. Kind of Business/Industry				
and old	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+)	KIII				
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d other event		ne (First, Middle,	Maiden Sumeme)			
Menta file e	Emmit Wheeler Johnson Esthe	r Thomps	son			
pull .	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)		
Health im 27 is ther tra	Jack Rubley (Husband) 11217 Bloomington Dri	ve, Tamp	pa, Florida	33635		
ant of He nt: If Nam ry or othe	20a. Method of Disposition 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Arlington National Cem.	08/08	20c. Location - City or Arlington,			
Departm Importa any inju	21. Signature of Europa Survice Licensee 22. Name and Address of Fecility Hardesty Funeral	Home, H		2.402		
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been signe should be d		24e. Was e		Were eutopsy findi evailable prior to completion of caus of death?		
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this certific ral director.	examiner?		lenca 6 Other (Spe	ecify)		
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within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time.					
within To the comple	29b. Signefure end title of certifier 29c. License number		29d. Date signed (Mon	oth, Dey, Year)		
)	11: 11 MD DIC187		1	1 200		
/	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)		40502)			
5	Ainee You 64 Franklin Avenue. Ann	apolis)	ND 5	1401		
State Registrar	31. Date filed (Month, Day, Year) AUG 0 4 2000 32. Registrar's Signeture					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 4 7 1 6

	Decedent's Name (First, Midd	la. Last)		Certi	ificate of	Death	2. Date of De	Reg. No.		3. Time of Death		
Physicia	Jack	How	ard	S	tineha	rt	Month	Day	Year	and the second		
/Medica	As Essilia Nome /// set institution					4b. City, Town, or Li	Augus ocation of Death			1:45 a		
Examine	Mariner Heal		*			Bel Ai:						
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	th Vosel	9. Birthp	lace (State or Foreign		
Director	215-01-2067	167M 2□ F	86	Yrs.	Months Days	Hours Min.	04/05/					
Pu km	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loca	ition				1	0d. Inside City Limits		
72 hours after death with the Manyland netural; or items 23s or 28s-f show deal Examiner must be notified at	PA Yorl	c	New	Park						1 ☐ Yes 2 No		
or 28	PA Yorl				10f. Zip Code		10g. Citizen of What Country?					
23a c		ve RD				17352	100	USA				
or Nema	11.1 Farm Grov	12. Was Decedent Armed Forces		13. Wa	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Ble				
or h	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give			Yes 2 No				v: Whi	te		
n 72 hours "natural",		Year or Dates:		16a. Decedent's Usual Occupation 16b. Kin						dustry		
hin 72	15. Deceder (Specify only higher Elementary/Secondary (0-12) 1 2	st grade completed)		(Give ki	nd of work done NOT use retired	during most of work	ing					
d 2 should be filed within 72 hours aft the and Mental Hygiane. If a marked other than "natural", or traumatic avant, the Medical Event	Elementary/Secondary (0-12)	College (1-4or		Sales	Manager			Retail	2000 1:45 a nty of Death r f o r d 9. Birthplace (State or Foreign Country) New York 10d. Inside City Limits 1			
be filed that Hygis d other avant, tr	17. Father's Name (First, Middle,					18. Mother's Name	e (First, Middle,	Maiden Sumar	ne)			
should be nd Mental marked o urmatic ava	Frank Charles	Stinehart				Netta Ca						
d 2 should th end Mer 7 la marks traumatic	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	and Number or Rur	al Route Numbe	er, City or Town	State, Zip	Code)		
of Heelth Itam 27 other tr	Margaret Podwe	ll Daughte			Farm Gr	ove RD Ne	w Park			wn State		
802	1 ☐ Burial 2 M Cremation											
permit. Pages 1 er Department of Hee Important: If itam 3 any injury or other page.	4 Donation 5 Other (S		Cnes		Cremate							
Depa Impo any I	1 W			736	Edmond	son Ave.	Baltim	ore, Md				
	23a. Part 1. Enter the disease, o strock, or hear failure. List	complications that ceuse only one cause on each	od the death.	Do not enter	the mode of dyir	ng, such as cerdiac	or respiratory a	rrest,	1	Intervel Between		
Physician		_		A +						Onset and Death		
/ /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Core	Jour	THY	en D	11 Sease			7	2,422.		
والمسال	Due to (or as e consequence of):											
axecuted in and fal-transit												
fleate be assouted physician and at the bunal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of):											
ficate be any physician as the buriel												
1 04	Tesuring in Gearth, Last											
death certification of for use a		d							1			
0 0 0	Part II. Other eignificant condition	^			erlying cause giv	ren in Part I.	23b. Did		entribute to	the cause of death?		
E X TO	COPD. (on gettur	the	arir	faul	he	10	Yes 2 No	3 Prol	bebly 4 □ Unknow		
* 52 £	Ronal	feelere			1		24a. Was	an autopsy				
been shou	Juna	ferre					perfo	med?	av.	ailable prior to mpletion of cause		
The law requir		,					400	Vac aldais				
certificata						26 Place of Don't	th (Chack only)	- / -	1	1 es 2 □ N0		
Physician: this certific rai director,		Hospital:	ient 2 ER	NOutnation:	3 DOA Oth	26. Place of Deet			ner (Specifi	v)		
g Phy er this		28a. Date of Inj		8b. Time of Injury	28c. Injur	-		how injury occu				
Attending in death.	1 Natural 5 Pendii 2 Accident investi	gation	2, 102/)	Hijury		Yes 2□No						
tal or Attending P is after death. al Director: After to in by the funeral control of the	3 Suicide 6 Could determ	riped 266. Place of In	niury - At home	e, farm, stree	t, factory, office		28f. Location (ber or Rura	al Route Number,		
ta la la la la la la la la la la la la la												
To the Hospital or Attending Physical Minin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral distributions.	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the best Examiner: On the basis of and manner s	of examination	edge, death on and/or inves	ccurred et the tir stigation, in my o	ne, date end place, pinion, deeth occur	end due to the red at the time,	cause(s) end m date and place,	enner as si end due to	tated. the ceuse(s)		
ithin of the comple	29b. Signature and title of certific	All the section of th	uriou.		29c. Licens	e number		29d. Date signe	ed (Month.	Day, Year)		
6 3 5 6	Win				03	2609		87210	A 1			
	30. Name and address of passes	who completed serves of	doub /lton 25	2a) /Time Br				7310	U			
10	30. Name and address of person	Millian.	MD 1	Tiog.	Revoli	ition st	Harre	De Gra	u M	021078		
State	24 Date Blad Afaith Day Year		rar's Signature		1							
Registrar		4.	6	1	,							

March March

Smutny, Andrew

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The lew requires that the death certificate be executiving a hours where death Division of Vital Records, P.O. Box 68760,

1. Decedent's Neme (First, M			Cei	rtificate of	Death		Reg. No.	00	C 4 / ./
	fiddle, Last)					2. Dete of De Month	Dey	Year	3. Time of Death
		JTNY .			lb. City. Town, or I	Augus		2000	12:45 pi
4e Facility Neme (If not insti Greater Ba	The second of the second		Cont		Towson			ounty of Death $1 \pm i mo$	
5. Sociel Security Number	6. Sex	7. Age (In yrs. I		If Undar 1 Yaer	If Under 24 Hrs.				pleca (State or Foreign
219-28-9222	103 M 2□ I		Yrs.	Months Deys	Hours Min.	April	20. 1		Md.
Isual Residence of Deceder		40.0%	T						
10a. Stete 10b. Co	unty		, Town or Lo						10d. Inside City Limits 1 ☐ Yas 2 ☑ No
Md . B	altimore		Towson	10f. Zip Code			10a Citiza	n of What Cou	
	ab Da						Tog. Citizei		ntry r
1008 Kenilwor		Decedent Evar in U.S	S. 13.1	21204 Wes Decedent of H		pecify Yes or No	- 14.	USA Race - Ameri	can Indian,
1 Nevar Merried 2	Armed Armed	forces?		If Yes, specify Cuba	in, Mexican, Puert	o Rican, atc.)		Black, Whita,	, etc.
3 ☐ Widowed 4 ☐ Divo	rced If Yes,	Give or Detes:		1 ☐ Yes 2 ☑ No	Specify:		Sp	pecify: Wi	nite
15. Dec	edent's Education	ed)	16e. Dece	dent's Usuel Occup kind of work done DO NOT use retired	etion during most of wor	kina	16b. Kind	of Business/Ir	ndustry
Etementary/Secondary (0-		e (1-4or 5+)				Jan.	D	G1 -	
12 17. Fathar's Nema (First, Mic	(dla l ast)	}	Ship	Superinte	ndent 18. Mother's Nan	ne /First Middle	-	Ship	
		nutny			Christi		Cather		Blazek
19e. Informent's Neme/Rale	-		19b. Mailie	ng Address (Street					
Ms. Andrea J.	Mullen/da	aughter	3 Du	nedin Ct.	Towson	, Md. 2	204		
20a. Method of Disposition		20b. Pl	laca of Dispo	osition (Neme of metory or other plea	1	Dete		tion - City or T	own, State
1 Buriel 2 Cremet 4 Donetion 5 Other		om State		Service C		3/4/00	Tows	on, Md	
21. Signature of Foceral Ser	vice bigensee			2. Name end Addre	ss of Facility				
Catothe	1011	to		1050 York	son Fune				
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants	b	Alcelo	r as a consecutive as a consecutive	/rex	dosea	/tem	ctur	73/6	Hours
resulting in death) Lest		000 10 (01	40 4 00/1004					t	
	d	a death but not resu	ulting in the u	nderlying cause on	en in Pert I	23h Did	lohacco us	e contribute 1	to the cause of death
Pert II. Other significant cor	ddiffens contributing to		1		, ,	-	/	No 3□ Pro	obably 4 Unknow
Pert II. Other significant cor			1		, ,	24e. Was	/	No 3 Pro	
Pert II. Other significant cor			1		, ,	24e. Was	Yes 2 en eutopsymmed?	No 3 Pro	Obably 4 Unknow Vere autopsy findings veilable prior to omplation of cause
Pert II. Other significant cor APPLYO 25. Wes case referred to me examiner?	SCLOVO)	hz ca	rdiz	Vus (n/	26. Place of Dec	24e. Was perfe	en eutopsymmed?	No 3 Pro 24b. W a' 0 0	Vere autopsy findings verilable prior to omplation of cause of death?
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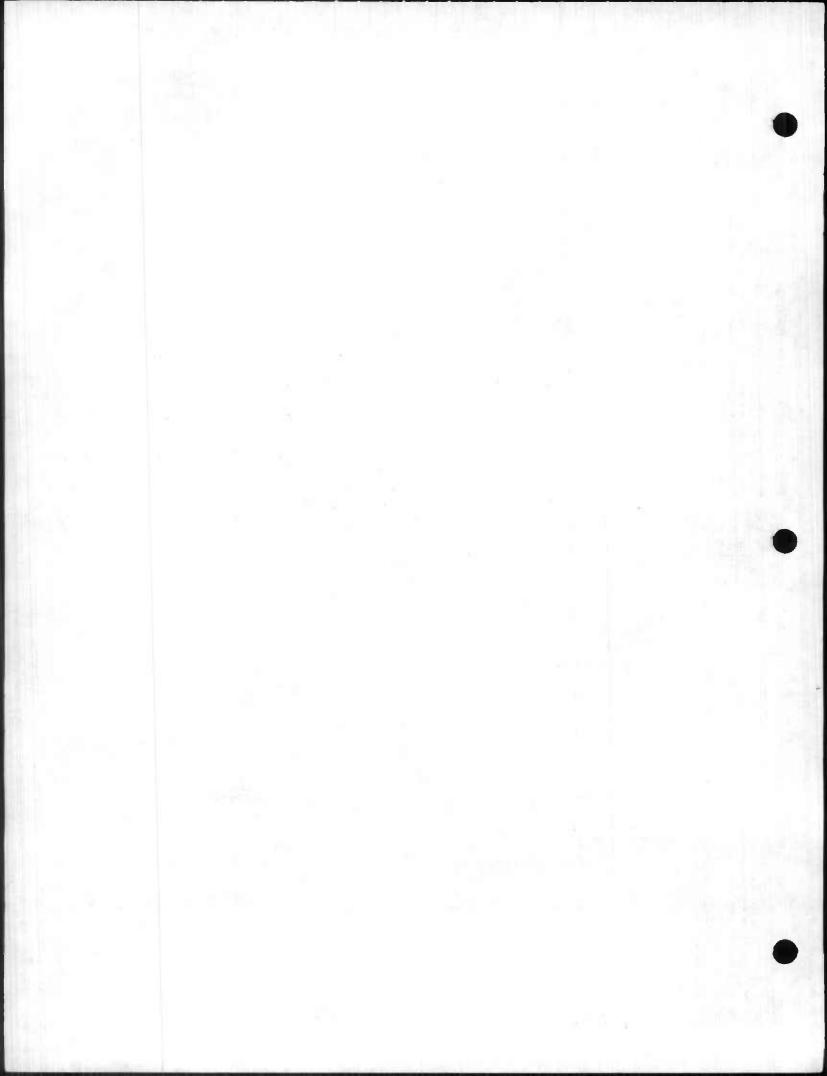
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			Oldic of M	arylaria i	Certifica	ite of Dea		norman riy	Reg. No.	24/18
Phys /Me	ician dical	1. Decedent's Name (First, Middle, L ARLINEA		IVA	7			2. Date of De Month AUGU	eath Day	Year 3: 40 PM
	niner	4s Facility Name (If not institution, go	111111111111111111111111111111111111111	CENT	ER		**	ocation of Dear	DA BA	of Death LTIFIORE
Funer Direct				ge (In yrs. last 38	Yrs. If Und Month		nder 24 Hrs. ours Min.	8. Date of Bir (Month, Da NOV • 2	1911	9. Birthplace (State or Foreign Country) Virginia
Maryland of show fled.et	tor	10a. State 10b. County Maryland Baltime	ore		own or Location Ochearn					10d. Inside City Limits 1 ☐ Yes 🌂 No
ar death with the Maryla Items 23a or 28a-1 show ner must be notified at	al Directo	10e. Street and Number 6811 Campfield	d Road			Zip Code 21207			10g. Citizen of V USA	Vhat Country?
	by Funeral	11. Marital Status 1 [X] Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			eedent of Hispan becify Cuban, Me 2 No Spa	ic Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. :: White
Maryland 21215-0020 of a should be filed within 72 hours at an and Mental Hygisten. The transmit event, the Medical Examination event, the Medical Examination.	Completed	15. Decedent's 8 (Specify only highest go Elementary/Secondary (0-12) Unknown	ducation ade completed) College (1-4or		6a. Decedent's Us (Give kind of a life. DO NOT Hairdres	vork done during use retired)	most of work	ing	Spring	g Grove Hospital
and be filed of other	88	17. Fether's Name (First, Middle, Las		licon					, Maiden Sumam	
aryle should marks marks	5	John Charles Spi 19a. Informant's Neme/Relationship		1	9b. Mailing Addre	1		. Vance		State, Zip Code)
- C - N -		Beverly Schoeber	lein (Frie				Ellic			land 21042
altimore, mit. Pages 1 a partment of He portant: if Item		20a. Method of Disposition 1X Buriat 2 Cremation 3 (4 Donation 5 Other (Special Control Cont		ceme	of Disposition (A etery, crematory of Lgs Bapt)	r other place)	etery 8	/5/00		city or Town, State vania, Virginia
Ball Pemit Depart Import	*SUC	21. Signature of Funeral Service Lice	3 Hens	2	Burge		Seitz		Home,	Inc. 21211
Dhominia		23a. Part1. Entre the disease, or conshock, or heart feilure. List only	nplications that caused one cause on each li	d the death. C	o not enter the m	ode of dying, suc	ch as cardiac	or respiretory e	rrest,	Approximete tnterval Between Onset and Death
Physicia /Medica Examine	al	Immediate Cause (Final disease or condition	. P	ULMI	ONAR	YE	DEL	TA		
	100	resulting in death)	0		a consequence of					1
58760, icate be executed physician and it the burial-transit	Examiner	Sequentially list conditions,	b		a consequence o					
68760, ificate be executed physician and as the burial-transit	edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	Due to (or as	a consequence of	n.				
E 08		resulting in death) Last	d	200 10 (0. 20	a sansoquanso o	,. 				
O. B. death	Physician/M	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the underlying	cause given in	Part I.	23b. Did	tobacco use cor	ntribute to the cause of death?
IS, P.O. I res that the de- signed by the a I be detached i	by Phy	DIABET	2 2			de la		10	Yes 2□ No	3□ Probably 4 및 Unknown
Por requi	Completed								an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
ai Rec The law cate has								10	Yes 2 No	1 ☐ Yes 2 ☐ No
ysicien: The scentificate director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Other		th (Check only		
Division of Vita or Attending Physicien: after death. Director: After this certifical in by the funeral director,	Itlon: To	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry 281	Outpatient 3 (28c. Injury et Work? 1 Yes			idence 6 Oth	
DIVISION After des after des after des de la Director del la D	Certification:	3 Suicide 6 Could not 4 Homicide determined		iury - At home, c. (Specify)	, farm, street, fact	ory, office		28f. Location (City or To		er or Rural Route Number,
DIVISION O To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical		hysician: To the best miner: On the basis of and manner st	f examination						anner as stated. and due to the cause(s)
To the To the comp	M	29b. Signature and title of certifier				9c. License num				d (Month, Day, Year)
	,V									72,2000
as		30. Name and address of person who MOKTHWEJT	HOSPIT	A / C	a) (Type, Print)	K.S.	RAO	1000	2 2 1	0
	state	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		lones	7116	-3100	- /	
Regis	strar	AUG 0 4 2	1111 22	never	D A	yours				

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 24719

														Reg. No.				
	1. Decedent	's Name	(First, Mia	idle, Last	1)	4	1110				. (1.11)	T	2. Date of De	elh Dev		Yeer	3. Time	of Death
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ner	4e Facility N	leme (II	not institut	ion, give	street end	num <i>ber)</i>					4b. City, To	wn, or L	ocation of Deal	h 4c.	County of	of Deeth		
	Great	er	Balt.	imor	re Me	edica	1 C	entei			Tows			В	alt.	imor	е	
	5. Social Sec	curity No	umber	6. Se	x □ M 200		(In yrs. la	st birthday)	If Under	er 1 Year s Deys		24 Hrs. Min.	8. Dete of Bit (Month, De	rth ey, Year)		9. Birthple Count	ace (Stete ry)	or Foreign
	216-2						69	Yrs.					Nov. 2	6, 19	930		Md	
	Usual Reside	ence of	10b. Coun	ity			10c. City,	Town or Lo	cation	_						10	d. Inside	City Limits
00																		s 2 No
901	Md.	and Nun	phor	N/	Α		Ва	ltimo		ip Code		-		10a Citis	zen of W	/hat Count	0/2	
Director													400	Tog. One		mat oouni	·y·	
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5			ed 2 M		Armed	Forces?		10.1	If Yes, sp	ecify Cub	en, Mexice	n, Puerto	ecify Yes or No Rican, etc.)			k, While, e		
			4 Divorce		If Yes.	Give or Deles:			1 ☐ Yes	2 ₹ No	Specify:				Specify:			
			15. Decede	ent's Edu				16a. Deced	dent's Us	uel Occu	petion			16b. Kir	nd of Bus	siness/Indi	ite ustry	
100			fy only high	nest grad	le complet			(Give	kind of w	vork done	during mos	t of work	ing					
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000	George	e		G	reen						Eva			Ko	las	inski		
	19a. informe	ent's Na	me/Relatio	nship (Ty	vpe, Print)			19b. Mailir	ng Addre	ss (Stree	-	er or Rui	al Route Numb					
	Mr. Ar					nusbar	nd						altimor					
	20e. Melhod						20b. Ple	ce of Dispo	sition (N	eme of			Dete			City or Tov	vn, Slate	
			Cremetion			om Slele		metery, crer					0/7/00					
	21. Signatur		5 Other				Gard				Cemet ess of Facili		8/7/00	Ove	rlea	, Md	•——	
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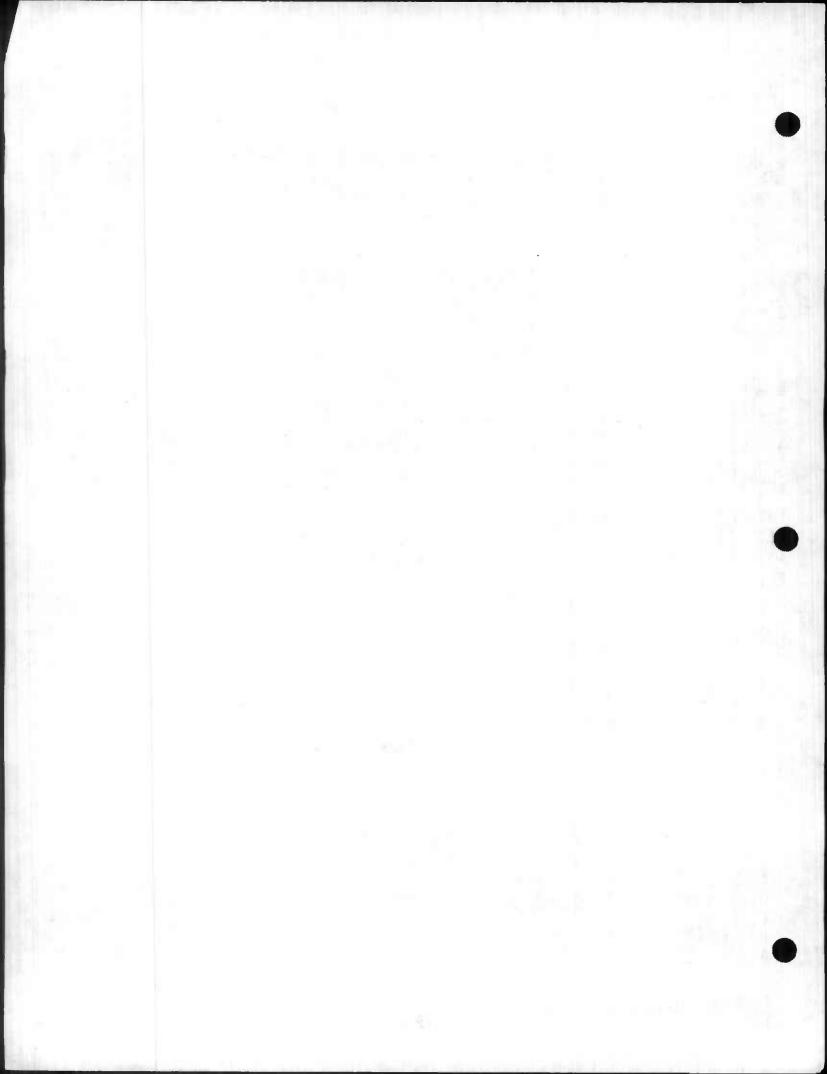
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32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 24721

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month **Physician** Robert Woodrow Thomas 4b. City, Town, or Location of Death 3:12 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 3563 Bensinger Rd. Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1€ M 2□ F 81 Yrs. Director 215-26-1009 10/06/1918 Maryland the Maryland 10a Stata 10b Counts 10c. City, Town or Location 10d. Inside City Limits Show ral', or itema 23a or 28a-f show MD N/A Baltimore N Yes 2 No Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 'netural', or itema 23a Funeral 3563 Bensinger Rd 21229 United States 14. Race - American Indian, Black White etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Yes 2 No 3/9/40
If Yas, Giva
Year or Datas: 8/13/4 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 € No Specify: 21215-0020 Specify: White A 3. Widowed 4 □ Divorced 8/13/45 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Sales Retail altimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) . Pages 1 and 2 should be fill ment of Health and Mental Hant; if Item 27 is marked off jury or other traumatic even Be Elsie May Painter Robert Edward Thomas 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 647 Charraway Rd. Baltimore, Maryland 21229 Barbara Thomas-Titus/Daughter 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Ramoval from State permit. Page Department of Important: If any Injury or once. Metro Crematory 8/7/00 Catonsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility Ambrose Funeral Home , Inc. 23a. Part1. Enfar the disease, of complice from their caused frind each. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 1328 Sulphur Spring Rd. Baltimore, Maryland 21227 **Physician** CONGESTIVE HEADT FAILURE /Medical Immedieta Cause (Final 4 YEAR. disaasa or condition resulting in death) Examiner Due to (or as a consequence of):

ANTERVENTUE HEBRIT DINEASE Dua to (or as e consequence of): Sequantially list conditions, if any, laading to immediala cause. Entar Underlying Cause (Diseese or injury that initiated events rasulting in death) Last BTHEDOICLE MOTIC HEADT DISEASE Physician/Medical Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYDERENSKON, DOTEDOSCLEDOTIC - Last 24b. Were autopsy findings available prior to completion of cause of death? Completed STHE BOSCLEDING 24a. Was an autopsy performed? Chapiac DREHNAMIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to sedical examinar? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Anesidence 6 Other (Specify) 1 Yas Certification: To ö 27. Manner of Death 1 Netural 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 5 Panding 1 Yes 2 No investigation 2 Accident after deat Director: 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 T Homicida 8 24 hours • Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Cartifiar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P within 2 To the F complet 29c. License number 29293 29d. Data signed (Month, Day, Year) 29b. Signafure and titla of certifier 30. Nama and address of person who completed caluse of death (Item 23a) (Type, Print)

RAPAS H-MARIN MD, 3455 WILLENS AVE, BALTO, MD, 21229 32. Registrar's Signature State Registrar

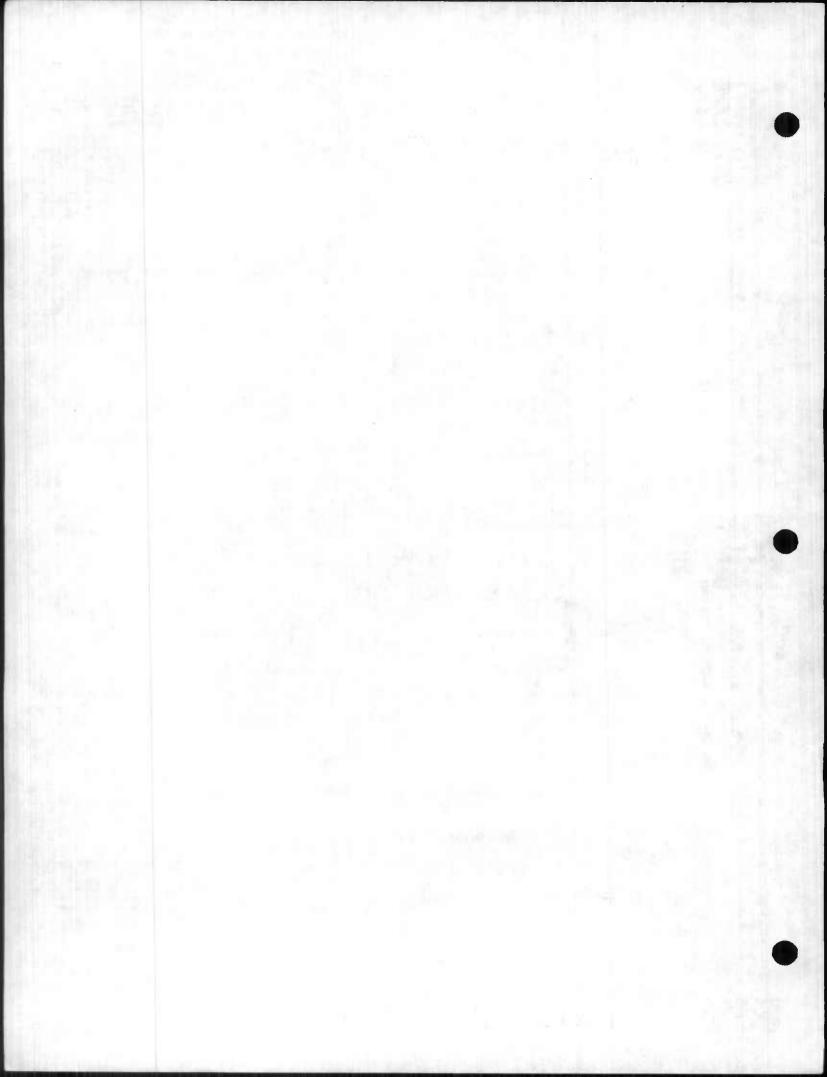
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		State of Marylan		te of Death		leg. No.	24123.
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	Usual Residence of Decedent						
with the Maryland a or 28a-f ahow be notified at Director	Maryland N/A		y, Town or Location altimore				10d. Inside City Limits XX Yes 2 No
ch with the Ma 23a or 28a-fs ust be notitled	10e. Street and Number 4112 Falls Road		10f. Z	21211		USA	ountry?
020 um after death v ef., or term 23a Examinet mett by Funeral	11. Merital Stalus 1XXVever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2000 If Yes, Give Yeer or Detes:	,S. 13. Was Dece If Yes, spo	dent of Hispenic Origin? ecity Cuben, Mexican, Pue	(Specify Yes or No- arto Rican, etc.)		
Maryland 21215-0020 d 2 should be flied within 72 hours at this and Mental Hygiene. This marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 8	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12)	cetion completed) Cottege (1-4or 5+)	lite. DO NOT	ork done during most of w use retired)	rorking	16b. Kind of Business/	Industry
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Baltimore, emil. Pages 1 at Department of Hea mportant: If Hean my Injury or othe INGS.	20a. Method of Disposition 1 ABurial 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	emoval from State	Place of Disposition (Necessary, crematory or Moodlawn Celesco	other place)	Dete 8/7/00 V	20c. Location - City or Woodlawn, M	
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State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture &	Sporks			



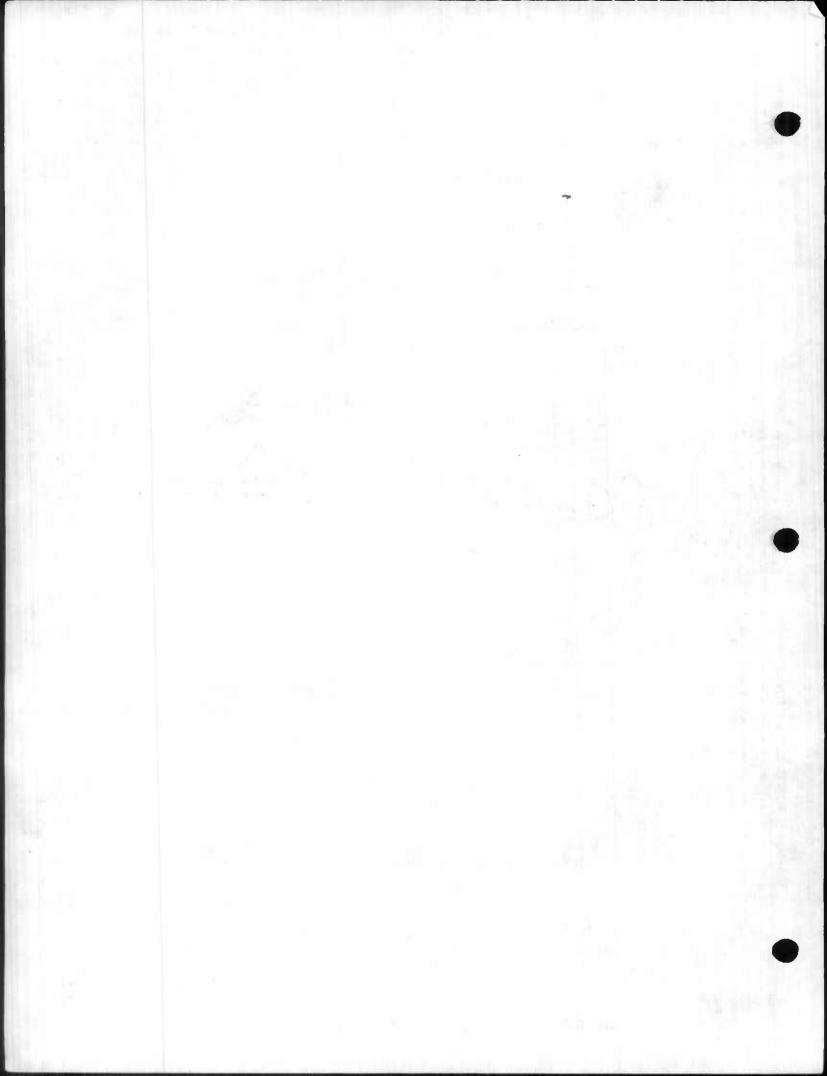
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State of Maryland / Department of Health and Mental Hygiene 24724 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death

Registrar DHMH 16 Rev 6/95

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	4a Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or L		4c. County of		
	FUTURE CARE CHES	SAPEAKE NURSI	NG HOME		ARNOLD		ANNE	ARUNDEI	L
eral ctor	5. Social Security Number 6. 8 212-01-3456		yrs. last birthday)	If Under 1 Yea Months Day		8. Data of Birth (Month, Day, JUNE 26		9. Birthplace (Si Country) MARY.LAN	
	Usual Residence of Decedent 10a. Stata 10b. County	10c.	City, Town or Lo	cation				10d. Insi	de City Limits
0	MARWI 1110	ADIBIDET		MNIA DOT T	5			10	Yas 2 No
Director	MARYLAND ANNE 10a. Street and Number	ARUNDEL	A	NNAPOLI:		11	Og. Citizen of W	hat Country?	
	1330 HARMONY LAN	JE			21401		U.S.A		
Funeral	11. Marital Status	12. Was Decedent Ever i	n U,S. 13. V		Hispanic Origin? (Sp	ecify Yas or No-	14. Race	- American India	ìn,
by Fur	1 Never Married 2€ Married 3 Widowed 4 Divorced	Armed Forces? X[X] Yes 2 □ No 1 If Yes, Give Year or Dates: 1	041	TYes, specify Co		Hican, etc.)		WHITE	
Completed	15. Decedent's E	ducation	16a. Deced	lent's Usual Occ	upation		16b. Kind of Bus	sinass/Industry	
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	12		BUSIN	ESS OWN	ER	3 1	OI	L	
99	17. Father's Name (First, Middle, Last	0			18. Mother's Nam	a (First, Middle, N	faiden Sumeme))	
2	HARRY		UT	Z	ELSIE		LAM	BERT	
	19a. Informant's Name/Relationship (MRS. PAULINE UT2				et and Number or Rur Y LANE, AN				
	20a. Method of Disposition 1)C Burial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State	b. Place of Dispos cemetery, cren EDAR HIL	netory or other p	le s	UG. 5,		City or Town, Sta	
al Examiner	Immediate Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.	NONCO o (or as a consequence o (or a consequence o (or a consequence o (or a consequence o	uence of):	to dy	spha. Jent	gia	ho	eks
	Part II. Other significant conditions of	contributing to death but not	resulting in the ur	nderlying cause	given in Part I.			tribute to the ca	. /
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State of Maryland / Department of Health and Mental Hygiene 24725 Certificate of Death 2. Date of Death 3. Time of Death Month WILSON august 2, 1709 2000

4b. City, Town, or Location of Death

4c. County of Death

Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Physician /Medical Examiner

Director with the Mandend 23a or 28a-f show the Medical Examiner must be notified at or items

filed within 72 hours after 3altimore, Maryland 21215-0020 þ Completed Be Peges 1 end 2 should be fil ment of Health end Mentel H lant: If Itam 27 is marked off Department of Health e Important: if Itam 27 is any injury or other training **Physician** /Medical Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed as the burial-tran P.O. Box 68760. page 2 should be detached 2 of Vital Records, Be Completed by or Attending Physician: after deeth. Division 1 Natural Director 3 Suicide To the Hospital within 24 hours a To the Funeral C

1. Decedent's Name (First, Middle, Last) NOLAN 4a Facility Name (If not institution, give street and number) JOHNS HOPKINS 5. Social Security Number 213-88-7985 Usual Residence of Decedent 10a. State Maryland Funeral Director 10e. Street and Number 11 Meritel Status 20a. Melhod of Disposition Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 1 Yes 2 No

HOSPITAL DAME If Under 24 Hrs. BALTIMORE CIT 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Months Days Hours Yrs. 10b. County 10c. City, Town or Location 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. Yes 2 No 1 Never Merried 2 Merried 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use religed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) trather 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)-20b. Place of Disposition (Name of Date 20c. Location - City or Town, State matery, crematory or other place) Burial 2 Cremation 3 Removel from State 4 Donation 5 Dother (Specify) -10h 21. Signature of Funeral Service Ocenser 22. Name and Address of Facility ner Joseph 2222 W. North Ave Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. ACUTE RESPIRATORY DISTRESS SYNDROME Due to (or es e consequence of): PNEUMOCYSTIS CARINII Due to (or as a consequence of) IMMUNO DEFICIENCY HUMAN Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 1 Yes 25. Wes case referred to medical 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury at Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier and manner stelled 29b. Signature and titte of certifier 29c. License number

12/2/6 al Approximate Intervat Between Onset and Death WEEKS WEEKS 2 YEARS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 X No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Ellen RES- 000 odd B MD AUGUST 2, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND 2128 JOHNS HOPKINS HOSPITAL BELLERIN

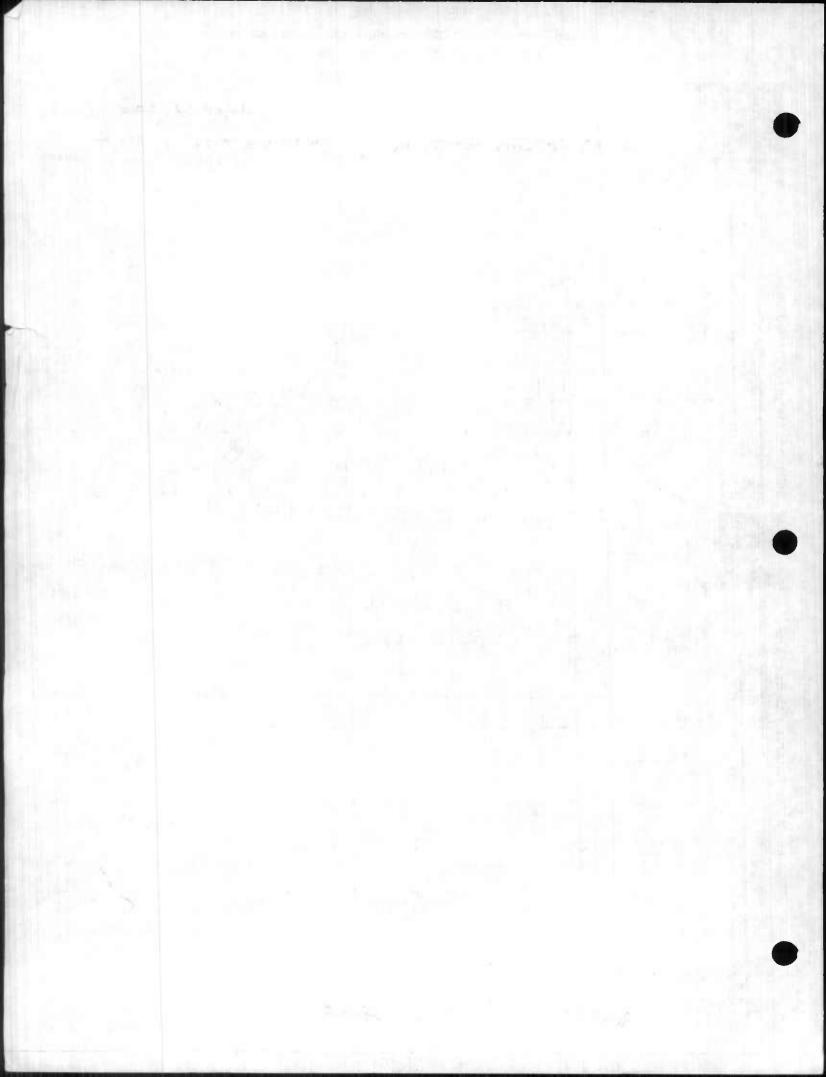
31. Date filed (Month, Day, Year)

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32. Registrar's Signatura

State Registrar



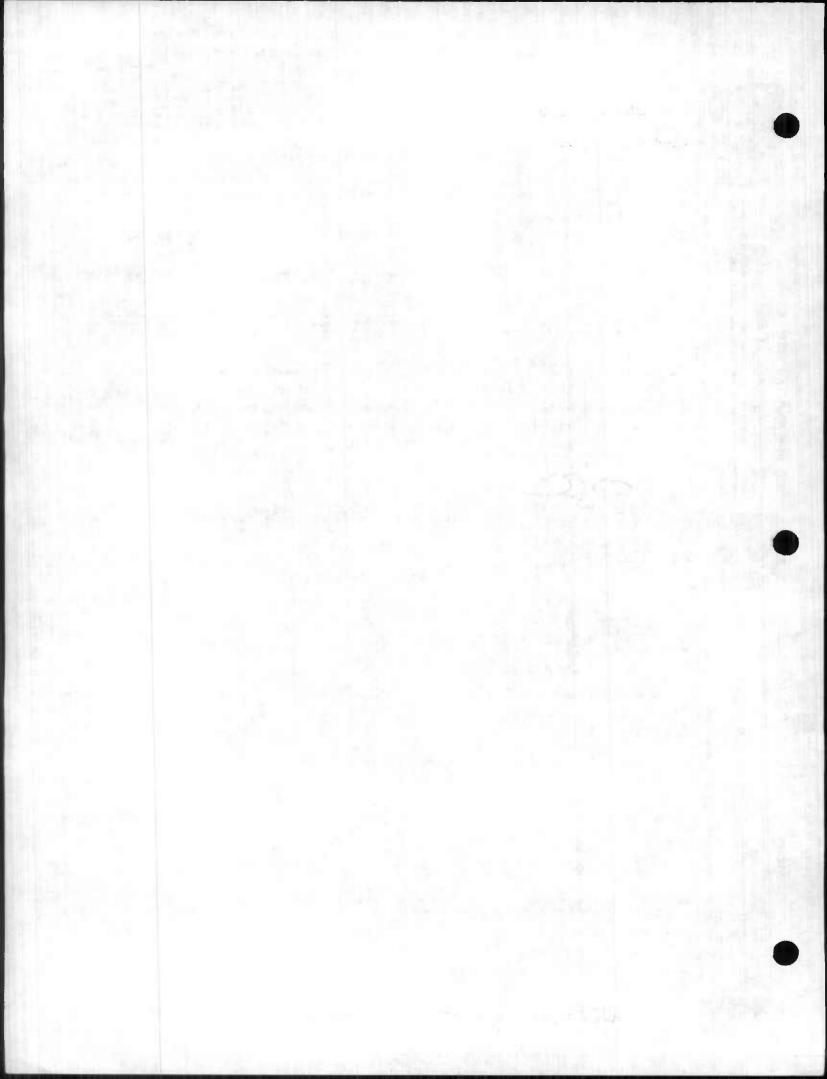
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 24726

				Cer	uncate	or Deali	1		Reg. No.		
Physician	1. Decedent's Neme (First, Middle	, Last)	10				191	2. Dete of De Month	ath Dey	Year	3. Time of Death
/Medical	Charles K. W							Aug.	2 20		2:30 AM
Examiner	4e Facility Neme (If not institution		nber)			4b. City, T	own, or Loc	cation of Deeth	0.00		
	Gilchrist Hospi		7 A (A (If Under 1		vson or 24 Hrs.	D. Data of Bir		altimo	
Funeral		6. Sex 1□M 2□F	7. Age (In yrs. I	Yrs.		Deys Hours	Min.	8. Date of Bir (Month, De	y, Year)		lece (State or Foreign
Director	213-66-9286 Usual Residence of Decedent	X	36					Aprii i	4 1964	Mar	yland
B & 11	10a. State 10b. County		10c. City	, Town or Lo	cation			-		1	Od. fnside City Limits
to to	MD Baltii	more	7	Timoni	um						1 ☐ Yes 2 ☐ No
be notified Director	10e. Street and Number			0.1.9.	10f. Zip C	Code			10g. Citizen of V	Vhet Coun	ntry?
	21 Tintern Ct.				2	1093			USA		
iner must	11. Marital Status	12. Was Dece	dent Ever in U,	S. 13. \		nt of Hispenic O y Cuben, Mexica	rigin? (Spec	cify Yes or No			an Indien,
	1 Never Merried 2 Marri	Armed For ad 1 Yes If Yes, Giv						nican, etc.)		k, White,	
9 6	3 ☐ Widowed 4 🂢 Divorced	Yeer or De	etes:		1 □ Yes 2	No Specify			Specify	Wh	ite
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al de	Elementery/Secondary (0-12)	College (1	-4or 5+)	life. I	DO NOT use	retired)					
Co	12	n/a		Retai	il			.=	Photo		
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To									eth Bra		
	19a. Informent's Name/Reletionsh								er, City or Town,		Code)
Per	Catherine E. M	cCaffrey/		21 T			Timoni		D 21093		Num State
o d	20e. Method of Disposition 1 ☐ Buriel 2 🗶 Cremetion	3 □Removel from S	State C	emetery, cren	netory or oth	ner place)	1	Dete	20c. Location -	City or To	own, Stete
luny	4 □ Donetion 5 □ Other (Sp		Ch			rematory		3/5/00	Beltsvi	ille,_	MD
N P	21. Signature of Fund of Service I	9134				Address of Feci					
	Michael JOF	lagle		1	0 W.	Padonia	Rd.	Timor	nium, M	D 210	093
0	23e. Part1. Enter the diseese, or shock, or heart failure. List	complications that ca	aused the deeth	. Do not ent	er the mode	of dying, such a	s cardiac or	r respiretory e	rrest,		Approximete Intervel Between
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dical niner	Immediate Ceuse (Finel disease or condition		olo	n	CO	ncer				1.5	5 years
	resulting in deeth)		Due to (or	r as a consec	quence of):					1	
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be deteched for up	Part II. Other significant condition	eb or gnitrioning to de	ain out not rest	ming in the u	nderlying ce	use given in Pen	11.		Yee 2 No	3 □ Prol	o the cause of death? bably 4 □ Unknown
be dete								10	2700	JUFFO	- DOUGHOWN
2 2									en eutopsy	24b. W	ere autopsy findings
should leted								perfe	med?	CO	allable prior to empletion of cause deeth?
hes mp									· Mar		
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S P	1 Yes 22No	-	npatient 2 of Injury	28b. Time of		401			dence 6 Poth how injury occur		A) Hospice
fon for	1 Staturel 5 Pending 2 Accident investig		of Injury h, Dey Year)	Injury	М	c. Injury et Work? 1 ☐ Yes 2 ☐					
by the	3 Suicide 6 Could n	ot be	of Injury - At ho	me, ferm, str	eet, fectory,			28f. Location (Street and Numb	er or Aure	al Route Number,
d in by the	4 Homicide	buildir	ng, etc. (Specif)	1)				City or To	wn, Stete)		
	29e. Certifier Certifying	Physician: To the	best of my know	wledge, deeth	n occurred e	t the time, dete s	and place, a	and due to the	ceuse(s) and me	anner as s	stated.
To the Funeral Director: After to completely filled in by the funeral Medical Certification:		xaminer: On the ba and mann	sis of examinet								
Me We	29b. Signalute and Alle of certifier	1	10		29c.	License number	r		29d Date signe	d (Month,	Day, Year)
,	El line	Thong 1	le	n au	0 1	1252	85		Auges	do	2000
1	30. Name and eddress of person v	vho completed cause	e of death (Man	23a) (Type	Print)			-	1		1
(M)	W.A. Riley	GBM		701 N	- 01	rles St	L. P.	ralto	Ms	515	36
State	31. Dete filed (Month, Dey, Year)	32. Re	egistrer's Signe		4	1 .					
Registrar	AUG 0 4	2000	Denin	2	1 1	oorks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Year Virginia R. Whitacre 10:30 AM 2000 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Sociel Security Number Baltimore City care If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 1 M X D F Months Deys 66 Yrs. 215-30-4192 Dec 28, 1933 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes x2 ☐ No Howard Maryland City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21043 8826 B Town & Country Blvd U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2⁄☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, While, etc. 1 Never Married 2 Married 1 Yes X No Specify: Specify: White 3x Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 7th 17. Fether's Name (First, Middle, Last). 18. Mother's Name (First, Middle, Meiden Sumeme) Virgil R. Clark Ruth E. Gary 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8822 Apt. D Town & Country Blvd. Ellicott City, Maryland 21043 LaRue Roberge 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 07/31/00 Sykesville, Maryland 4 Donetion 5 Other (Specify) All County Cremation Services, Inc. Funeral Service Licens 22. Name end Address of Fecility Slack Funeral Home, P.A. WOIII3 3871 Old Columbia Pike Ellicott City, MD 21043 bese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, it. List only one cause on each line. Immediate Ceuse (Finei 4 months diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert fl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No 24b. Were eutopsy findings evellable prior to 24e. Wes en eutopsy performed? completion of ceuse of deeth? 2 No 1 Yes 20 No 1 Yes 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Vinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Examiner buriel-transit pue the been signed by the a should be detached it After this cartificate has director, page 2

or Attendate after deat Director: Hospital 24 hours Funeral I

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f ehor the Medical Examiner must be notified at

Directo

Funeral

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Completed

the Marylend

death

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filled within Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "

injury or other

Physician /Medical

Examiner

Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

To the To the To the

29b. Signatore end title of certifier

29c. License number

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29d. Date signed (Month, Dey, Year)

Maulande, MD hodo

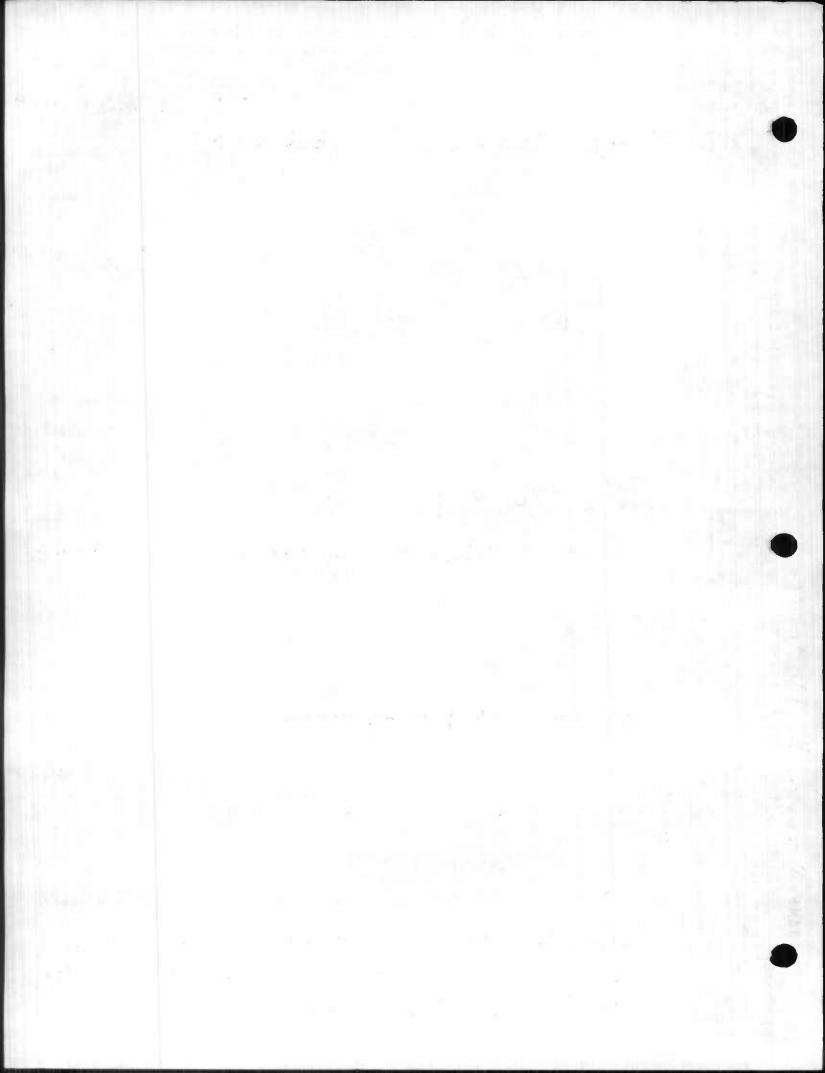
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30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

ST MUTOMBO KANKONDE

ACNES HOSPITAL

State Registrar



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24728 Amended item#13 perFHG787 9/5/2000 EW AMENDED ITEMS #17, #19a PER INFORMANT G786 8/14/00 AH Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Timothy 16,00 Wool ford 2000 9457 2 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 243 Bynum Ridge Road Forest Hill Harford 6. Sex 10 M 20 F If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 28, 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 48 Yrs. 218-46-3704 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itema 23a or 28a-f ahow treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Harford Forest Hill Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? S. A. 14. Race - American Indian, Black, Whita, atc. Funeral 243 Bynum Ridge Road 21050 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Giva Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dorse during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondery (0-12) College (1-4or 5+) Fire Fighter Baltimore Fire Department 18. Mother's Name (First, Middle, Maideri Sumame) 17. Fathar's Nama (First, Middle, Last) WOODROW WILSON WOOLFORD Mentel 1 and 2 should be is marked of Woodrow Wilson Woodford Bertha Katherine Tauber 19a Informant's Neme/Relationship (Type, Print) MRS. SHERREE R. WOOLFORD-WIFE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Hem 27 I 243 Bynum Ridge Rd. Forest Hill, Maryland 21050 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If Ih any injury or o 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-7-2000 Towson, Md. 22. Name and Address of Facility Leonard J. Ruck Funeral Home Inc 21. Signature of Funeral Sarvice Licenses 5305 Harford Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Onsat and Death Physician Glioblastoma Immediate Cause (Final disaase or condition resulting in death) /Medical 4 month Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca of) use es the bunal-tran Box 68760, the attending physician that initiated events resulting in death) Last Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy After this certificate has 2 No 1 Yes 1 □ Yes 2 □ No is after death.

And Director. After this ceru...

In by the funeral director, pe or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Injury et Work? 1 Netural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Funeral C 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and Itie of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Far

Registrar **DHMH 16 Rev 6/95**

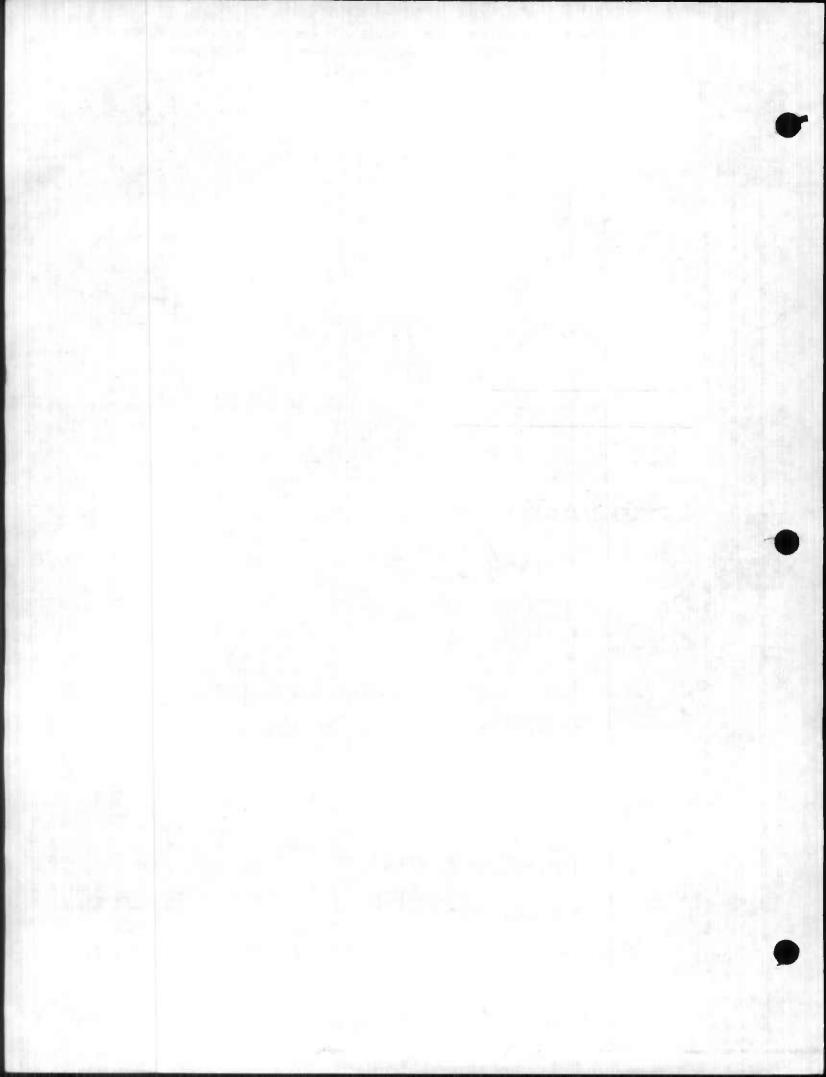
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31. Data filed (Month, Day, Year

32. Ragistrar's Signature

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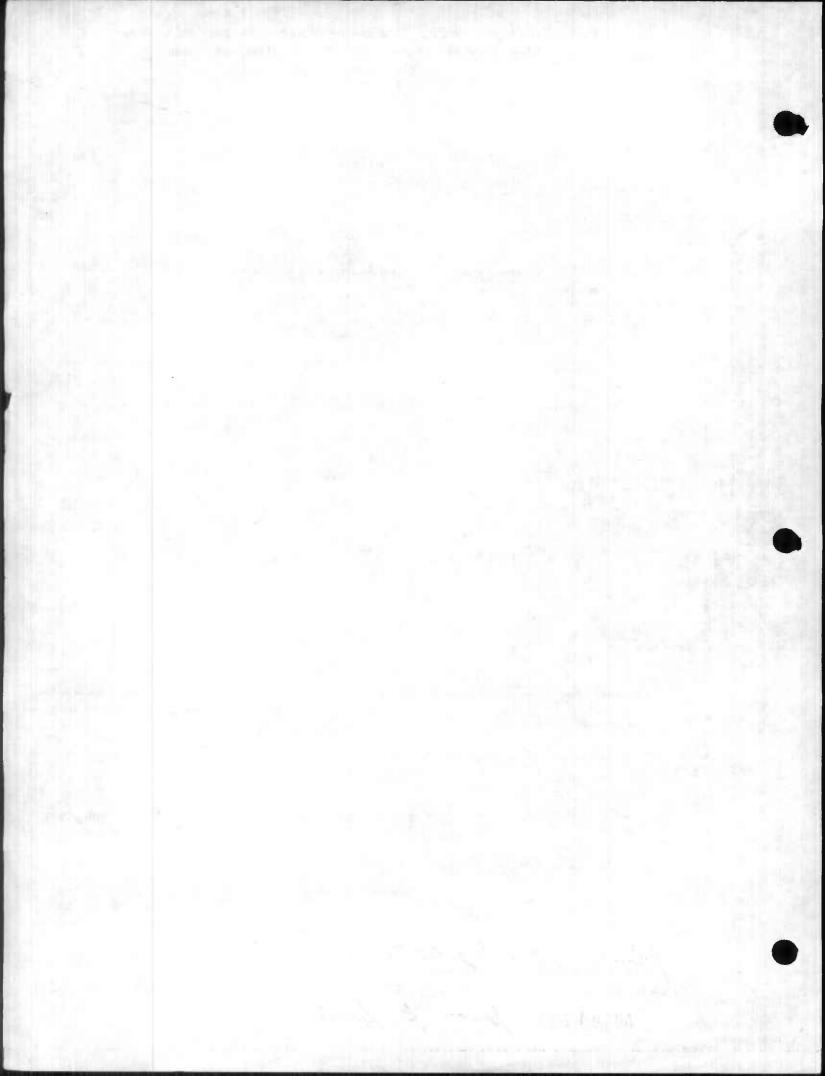


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2000 9:50 A.M. Genevie Frances Weidner August /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Be1 1613 S. Tollgate Road Air Harford Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 KF Yrs. 8, 84 Nov. Director 212-01-9506 MD Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 28a-fahow permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryle Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show my in jury or other traumatic event, the Wedgel Examinet must be notified and 1 Yes 2 No Funeral Director Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 8025 **Duvall** Avenue USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -Americen Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be Steck Katherine Walters Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Arno Weidner/Husband 8025 Duvall Avenue, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 8-4-00 | Baltimore, MD Metro Crematory of Funeral Service Letin 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21237 Chesaco Avenue, Baltimore, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heer tailure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence ot): Examine ate has been signed by the attending physician and page 2 should be detached for use as the bunal-trensit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse ot death? 24a. Was an autopsy performed? Completed 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

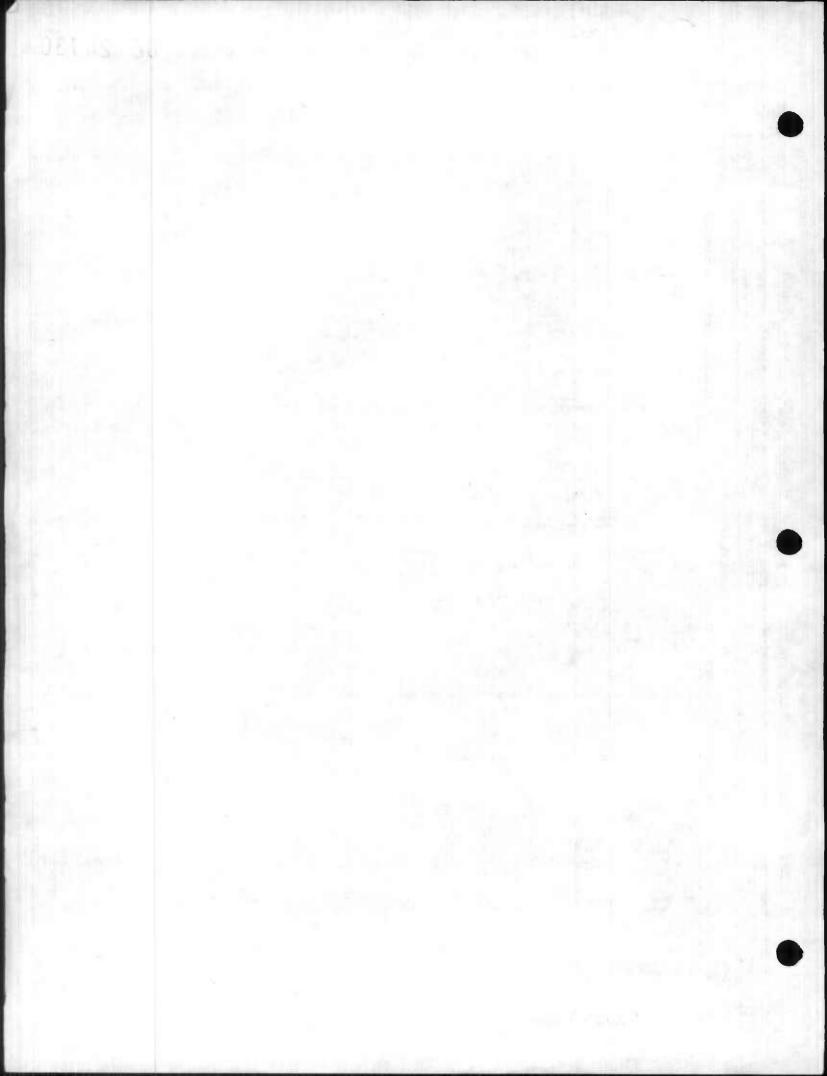
To the Funeral Director: After this certifica completaly filled in by the funeral director, I Be 25. Was cese referred to medical examiner? 26. Piece ot Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To 6 Other (Specify Mess 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 T Homicida 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and maliner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signati and address of person who completed cause th (Item 23a) (Type, Print) Merri DAlla MP 63 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2000 Registrar

DHMH 16 Rev 6/95



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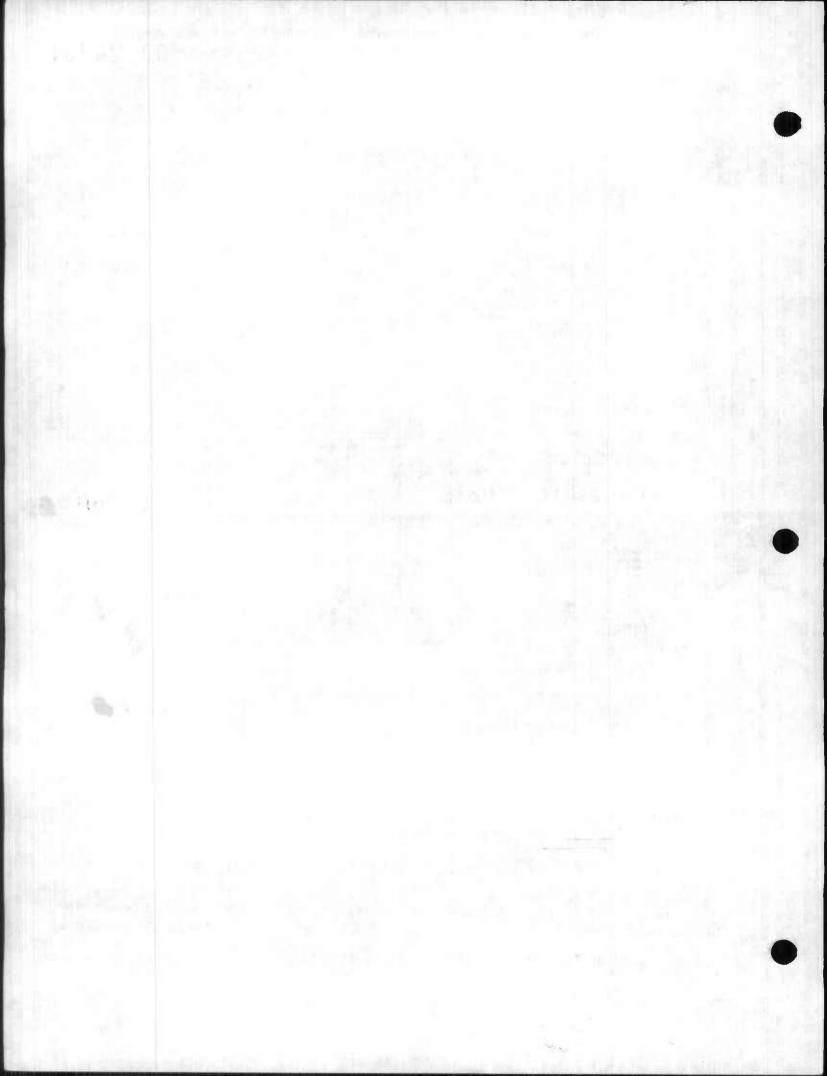
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	sician edical	Ma	rie D. B	ea1				3, 2000	4:05 A	AM
	miner	4a Facility Name (If not institution, give s	street and number)			4b. City, Town, or	Location of Death	4c. County of	Death	
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Fune Diréc		212-10-2302	7. Age (i	In yrs. last birth	Months rs.	1 Year If Under 24 Hrs Days Hours Min.	(Month, Day,		9. Birthplace (State or Fore Country) Maryland	ign
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21215-0020 ct within 72 hours at pens. or than "natural", or the Maddool Every		15. Decedent'a Educ	cation	16a. I	Decedant's Usual	Occupation		16b. Kind of Busi	ness/Industry	
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Pages 1 and the rest of Heart		20a. Method of Disposition 1 ☐ Burlal 2 🖾 Cremation 3 ☐ Re	amovel from State	20b. Place of cemetery	Disposition (Name, crematory or of	e of her place)	Date	20c. Location - C	ity or Town, State	
Page Page ment of		4 □ Donation 5 □ Other (Specify)	emoval nom State	Metro	Cremat	ory, Inc.	8/5/00	Baltimo	ore. MD	
alt military portion	8	21. Signature of Funeral Service License	9 15	1	22. Name and	Address of Facility abb Funera			,	
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Physici	an	Shook, or heart failule. Caronly on	a causa on each inte.	4	1				Onset and Death	
/Medic	_	Immediate Cause (Final diseasa or condition	Recur	heret	Colo	n can	rein		7 month	15
Examin		resulting in death)			onsequenca of):					
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68760, fileate be exect physician and and the buriel-tra	E	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events								
68760, ficate be experience to physician	d C	that initiated events resulting in death) Last	Du	e to (or as e co	ensequence of):					
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Box eath cert attendin	Physician/N									
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Or or or or or or or or or or or or or or	e						24a. Was a perform	ned?	24b. Were autopsy finding available prior to completion of cause	Ja
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ng P	50	27. Manger of Death 1 Matural 5 ☐ Pending	28a. Data of Injury (Month, Day Y	ear) 28b. Ti		Bc. Injury at Work?	28d. Describe ho	ow Injury occurre	3	
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Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours effer death. To the Furner al Director: After this certificate he completely filled in by the funeral director page	2	200 Contine	International Control		de alle en	A AL - A' A				
Hosp 24 ho Fund	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of ex	amination and	death occurred a for investigation,	it the time, date and place In my opinion, death occu	rred at the tima, d	ause(s) and man ate and place, ar	nar as atated. id dua to tha cause(s)	
ithin ithe	2	29b. Signature and allie of conflier	and mannar stated	J.	29c.	License number	_ 2	9d. Date signed	(Month, Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene 0 0 2 1 7 3 1

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Pert II. Other signif	icant conditions c	ontributing to death t	but not resulti	ing in the unde	erlying ceuse giv	ren in Part I.	23b. Did	i tobacco use cor	ntribute to the o	cause of de
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3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Plece of in	njury - At homoto. (Specify)	e, farm, atreet	t, factory, office				er or Aurel Aou	te Number.
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 0 24732

			C	ertificate	of D	eath		F	leg. No. U U	1 6	4/32
	1. Decedent's Nema (First, Middle, L.	est)					2	2. Dete of Dea			3. Tima of Death
Physician	Stanley Jo	seph		Buzgiers	ski	Sr.	A	Month	3 20	Year 000	9:45 PM
/Medical Examiner	4a Facility Nama (If not institution, gi							ation of Death	4c. County		J. 13 111
LAdililier	706 South 51'st	Stroot				unda	112		Balt	imoro	
Company			(In yrs. last birthd	(av) If Under 1		f Undar 2		. Data of Birtl			laca (State or Foreign
Funeral Director	215-30-4090 Usual Rasidence of Decedent	1∑ M 2□ F	71 Yrs	Months	Days	Hours	Min.	Data of Birtl (Month, Day ay 10	L929	Coun	yland
pun Mar	10a. State 10b. County		10c. City, Town o	r Location						10	0d. Inside City Limits
with the Maryland a or 28a-f show Lbs.notified.st	Md. Baltim	ore	Dundalk								1 ☐ Yes 2 📉 No
or death with the Maryla lterns 23a or 28a-f show the must be notified at 'umeral Director				10f. Zip C	1224				Iog. Citizen of V		
	4.2	12. Was Decedent En Armed Forces? 1 Yes 2 No. If Yes, Giva	1951 1953	I3. Was Decede If Yes, specif 1 ☐ Yes 2		anic Orig Mexican, Specify:	in? (Speci , Puerto Ri	ify Yas or No- can, atc.)	Bled	e - Americ ck, Whita, o Whi	atc.
2 hours satural scale.	15. Decedent's E		16a. De	ecedent's Usual	Occupation	on			16b. Kind of Bu		
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Maryland 42 should be file h and Mertal Hy 7 is marked othe traumatic event	19a. Informant's Name/Reletionship	(Type, Print)	19b. M	ailing Address (Street and	d Number	r or Rural i	Route Numbe	r, City or Town,	State, Zip	Code)
M 22 12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Patricia Buzgiers	ci (Wife)	706	South !	51'st	Str	ceet 1	Dundall	c, Md.	21224	
D 25 8 8	20a. Method of Disposition		20b. Place of Di		e of		-	gest	20c. Location -		
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n 24 houp n 24 hou ne Funer pletaly fil	(Check only 2 Medical Example)	miner: On the basis of a and manner state	xamination and/o	r investigation, i	n my opini	ion, deeth	h occurred	et the time, o	ete end plece,	and due to	the cause(s)
Within To the comple	29b. Signatura and title of certifier			29c.	License n	umber		2	9d. Data signe	d (Month, i	Day, Year)
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3.0	30. Nama and eddress of person who ROBERT CONNOR		ith (flom 23a) (Typ HERRLT).	BAL	TIMO			2122	
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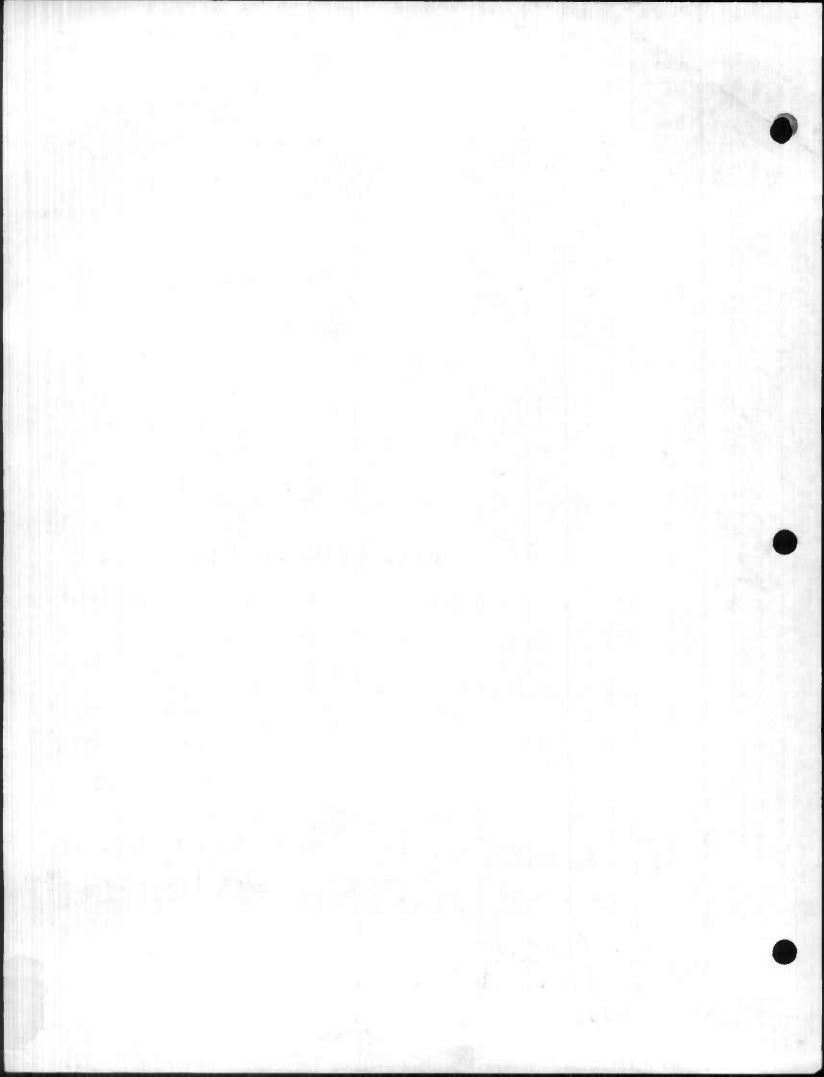
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					Cer	tificate of	Death	F	Reg. No.			
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State Registrar

DHMH 16 Rev 6/95

Date filed (Mgrith, Dey, Year) AUG 0 7 2000 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Amended item# 25.11 G 786 8-14-00 wjj Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^{Day} 2000 Month **Physician** August 5, 9:50 AM Roberta S. Bradenbaugh /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Overlea Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Months Yrs. August 15,1922 West Virginia 212-22-2134 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 23s-1 show say injury or other traumatic event, the Medical Examiner must be notified at once. MD 1 Yes 2 No Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1510 Kennewick Rd. 21218 U.S.A. Funeral Was Decadent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Office worker/Rivetor 12 yrs. Airplane manufacture 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Edward Schreffler Sally 19a. Informant's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Bradenbaugh, Jr.-Husb 1510 Kennewick Rd., Baltimore, MD 21218 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/8/00 Towson, MD 22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc 21. Signature of Funeral Service Licensee William G. Dau 5305 Harford Rd., Baltimore, MD 21214 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical mth Examiner Due to (or as a consequence ot): Physician/Medical Examiner etastasis bran attending physician end for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): sided Box 68760, weakness Due to (or as a consequence of) USB BS ans Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Hhknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy periormed? Completed peeu ANEMID has I page 1 Yes 2 No 1 Yes 2 TNo certificata Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury at Work? After 1 Natural or Attending 5 Pending investigation s after deeth.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. edicai 29a. Certitier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D3146 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUTAN St Sinte 308, Bult. MD2120 SHOAIB 1 mt cot

Registrar **DHMH 16 Rev 6/95**

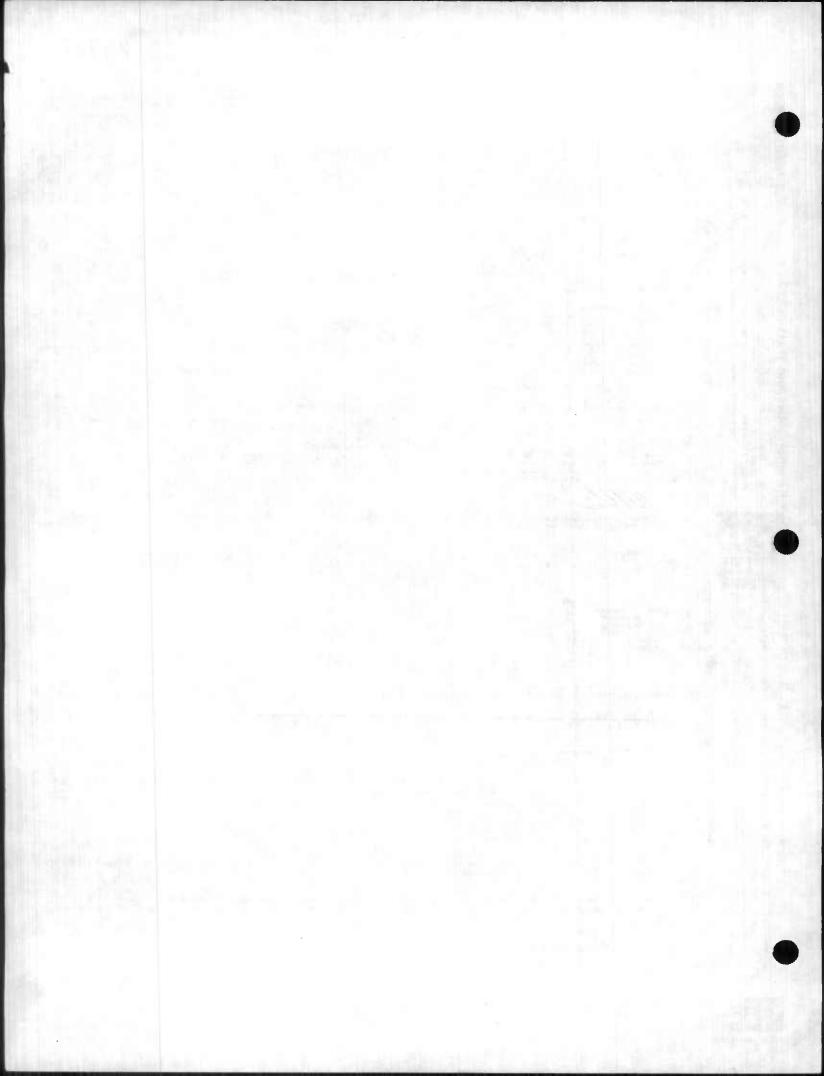
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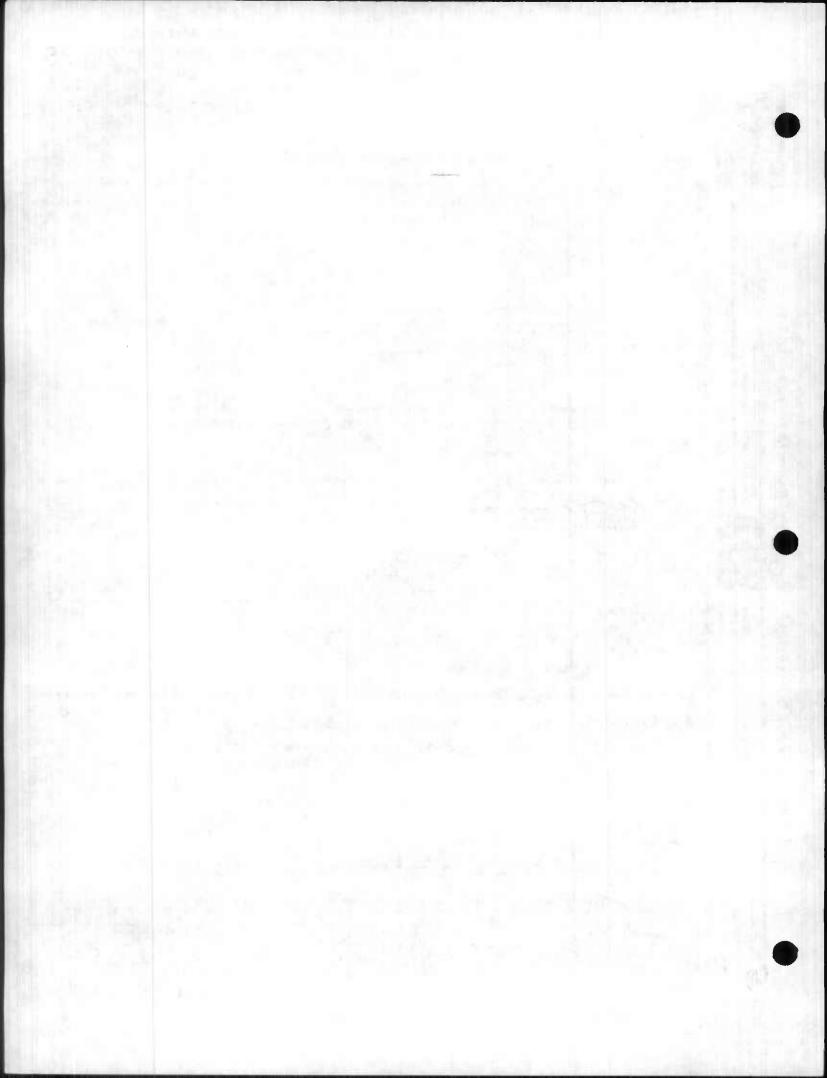
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32. Registrar's Signature

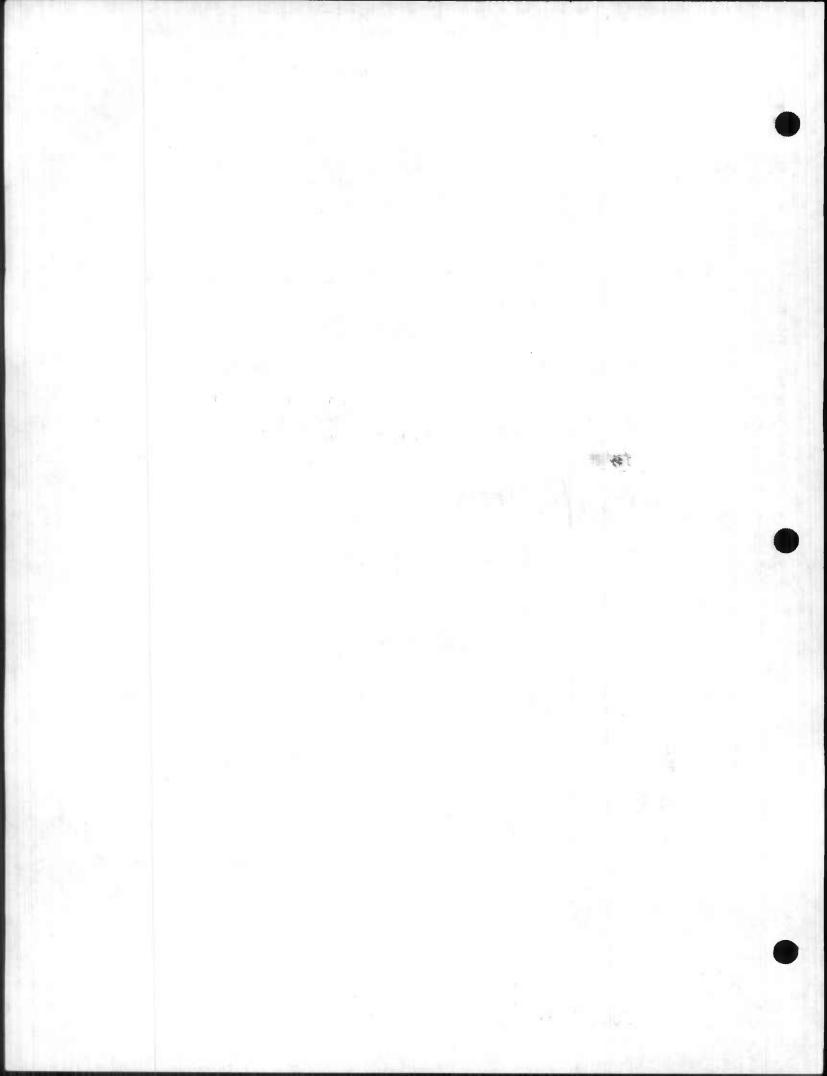


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Physician /Medical		ARLES			BRENNER		AUGUST 2, 200		00	10:50 AM	
Examiner	4e Fecility Name (If not instituted MILFORD MAN					4b. City, Town, or L BALTIMC	1.50		ty of Deeth LTIMORE		
Funeral Director	5. Social Security Number 218–32–3030	6. Sex 1 (X) M 2 □ F		s. lest birthdey)	Months Deys		8. Dete of Birth (Month, Day, OCT . 20,	1898	9. Birthy Cou	olece (Stete or Fore	
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the north	10e. Street and Number 3737 COURTI	EIGH DRIVE			10f. Zip Code	21133	10	g. Citizen of		ntry?	
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tel tygiene. d other than "natural, or he event, the Medical Examina Be Completed by Fu	15. Deced (Specify only hig Elementary/Secondary (0-12	ent's Education hest grade completed, 2) College (1-4or 5+)	16a. Dece (Give life. GROC		pation during most of work ad)	king	FOC		dustry	
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10 10	20e. Method of Disposition ↑ Burial 2 ☐ Cremetion Donetion 5 ☐ Other		State	cemetery, cre	osition (Name of metory or other pla ZION CEMI		Dete 2 8/4/00	20c. Location ROS	- City or To		
Depertment Important: any injury once.	21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility SOL LEVINSON & 8900 REISTERSTOWN ROAD — PIKESVIL.								BROS	S., INC.	
ng physician and e es the buriel-trensit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b	Pr Due to	(or es e consecutor (or es e consecutor es e c	quenca of):	SIA				2014	
te has been signed by the attending page 2 should be detached for use as completed by Physician/Mec	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobac								bacco use contribute to the cause of deat		
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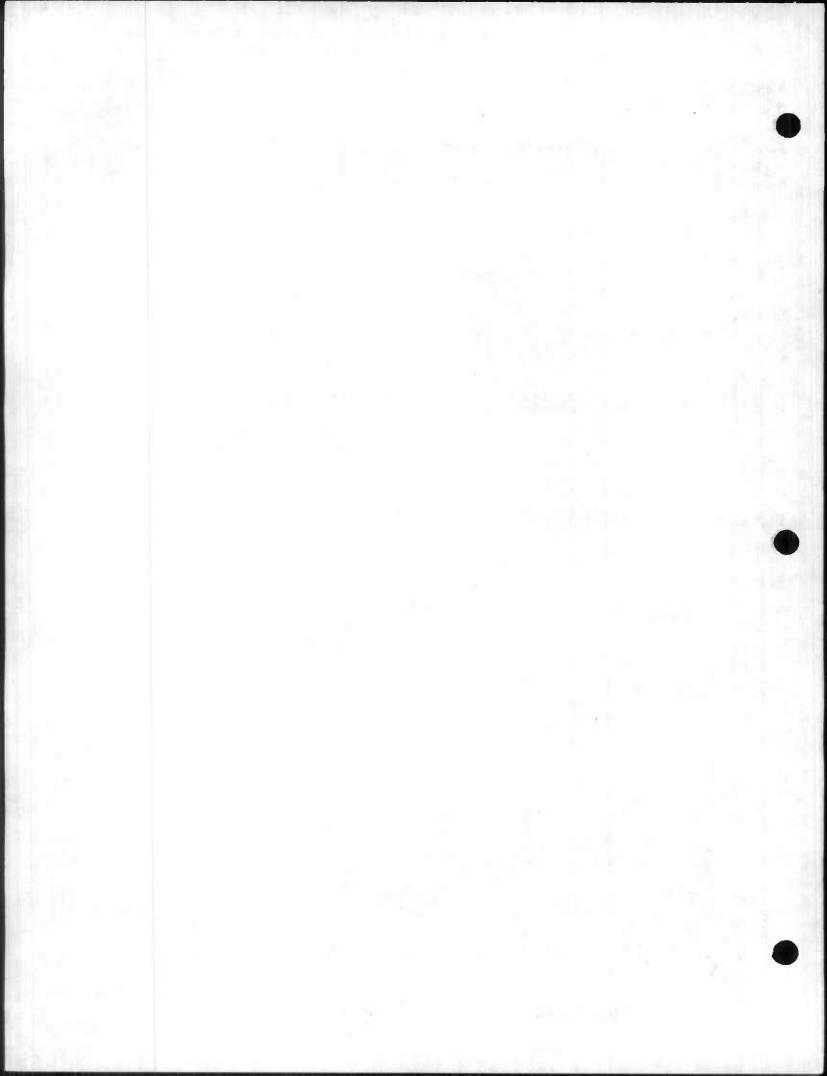
State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg. No.	0 2	4731
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Examiner	4a Facility Name (If not institution, g	ive street end number)				4b. City, Town, or L	ocation of Death	4c. County	of Death	
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within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determine	d 286. Pieca of in	ury - At home, fe c. (Specify)	orm, street, facto	ory, office		28f. Location (S City or Tox	Street end Numb vn, State)	er or Aural	Route Number,
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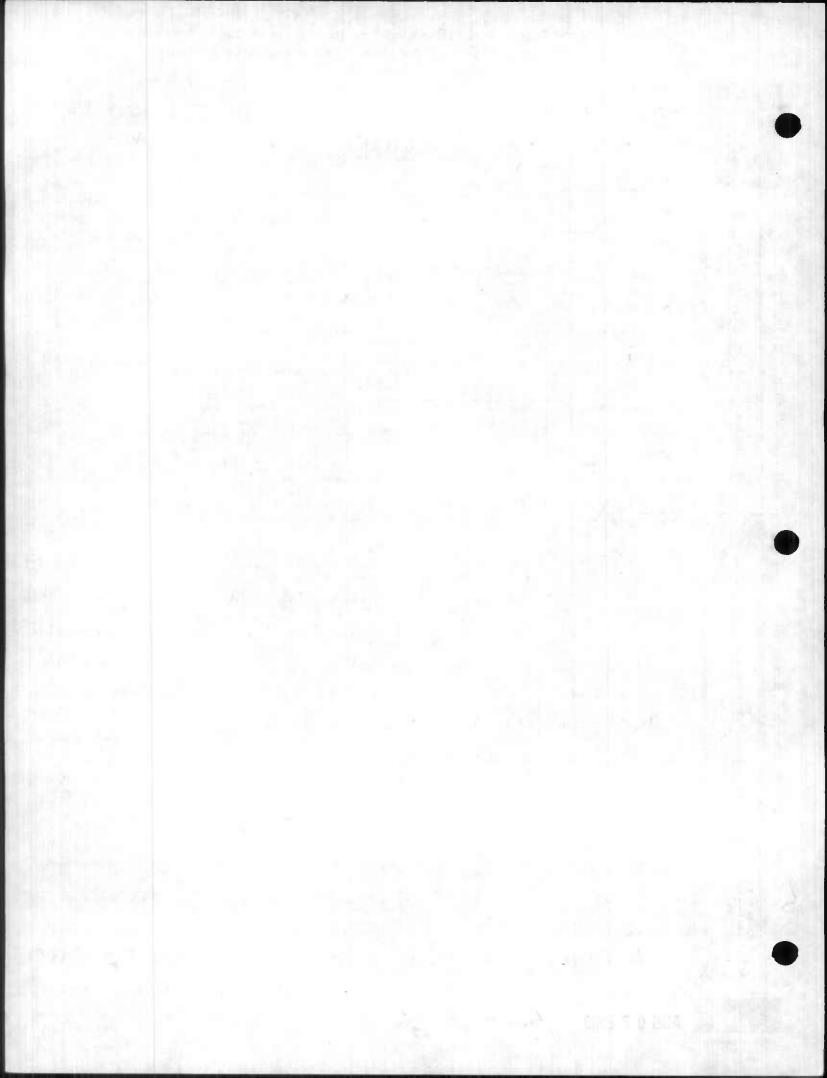
State of Maryland / Department of Health and Mental Hygiene 00 24737

				Cei	rtificat	e of	Death			Reg. No.		
	1. Decedent's Name (First, Middle	, Last)		1					2. Date of De		M. Control	3. Time of Death
Physician	KATHRYN CRUTCI	HFIELD							AUG	Day	Year 000	2:50 PM
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5	5. Social Security Number	6. Sex	7. Age (In yrs. k		If Unde	1 Year	If Under		8. Date of Bi	rth		lace (State or Foreign
Funeral Director	214-03-6780 Usual Residence of Decedent	1□ M 2∏ F	89	Yrs.	Months	Days	Hours	Min.	May 3	ey, Year)		place (State or Foreign http) yland
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hours after death virus 23 at Examiner must od by Furneral		Armed Formed To 1 Yes If Yas, Gir	ZX No	s? If Yes, specify Cuban, Mexican, Puerto ☐ No 1 ☐ Yes ②☐ No Specify:				n, Puerto	ecity Yes or Ne Rican, etc.)	Black	- Americ k, White, White	
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the state of	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Addres	s (Street	and Numb	ar or Run	ei Route Numl	per, City or Town,	State, Zip	Coda)
and 2	H. Carlton Cruto	chfield/S	pouse	3004	Nort	h Ri	dge F	Road	Ellico	tt City,	Md.	21043
S Hand	20a. Method of Disposition		20b. Pl	ece of Dispo	sition (Ne	me of			Date	20c. Location - 0		
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	23a. Part1. Enter the disease, or shock, or haart failure. List	complications that o	caused the death	. Do not ent	er the mod	de of dyir	ng, such as	cardiac	or respiratory	arrest,		Approximate Interval Between
Physician /Medical Examiner	Immediata Cause (Final disease or condition rasulting in daath)	a	Due to (or	es e consec	quence of)			H	<u> </u>		alle and a second	
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within To the comple	29b. Signature and little of certifier	10 0			29	c. Licens	e number			29d. Date signed	(Month,	Dey, Year)
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4	Elizabeth Bow	er, M.D.	3460 E.	llicot	t CE	nter	DRiv	e #1	03/E11i	cott Cit	y MD	21043
State Registrar	31. Date filed (Month, Day, Year)	2000 32. F	Registrar's Signat	ure &	1	oars	6					



State of Maryland / Department of Health and Mental Hygiene 00 24738

Physician ROSA CAYMOND ROSA CAY				Certifica	te of Death		Reg. No.		
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The state of the s	h wit	411 MAPLE LANE			21222		IISA		
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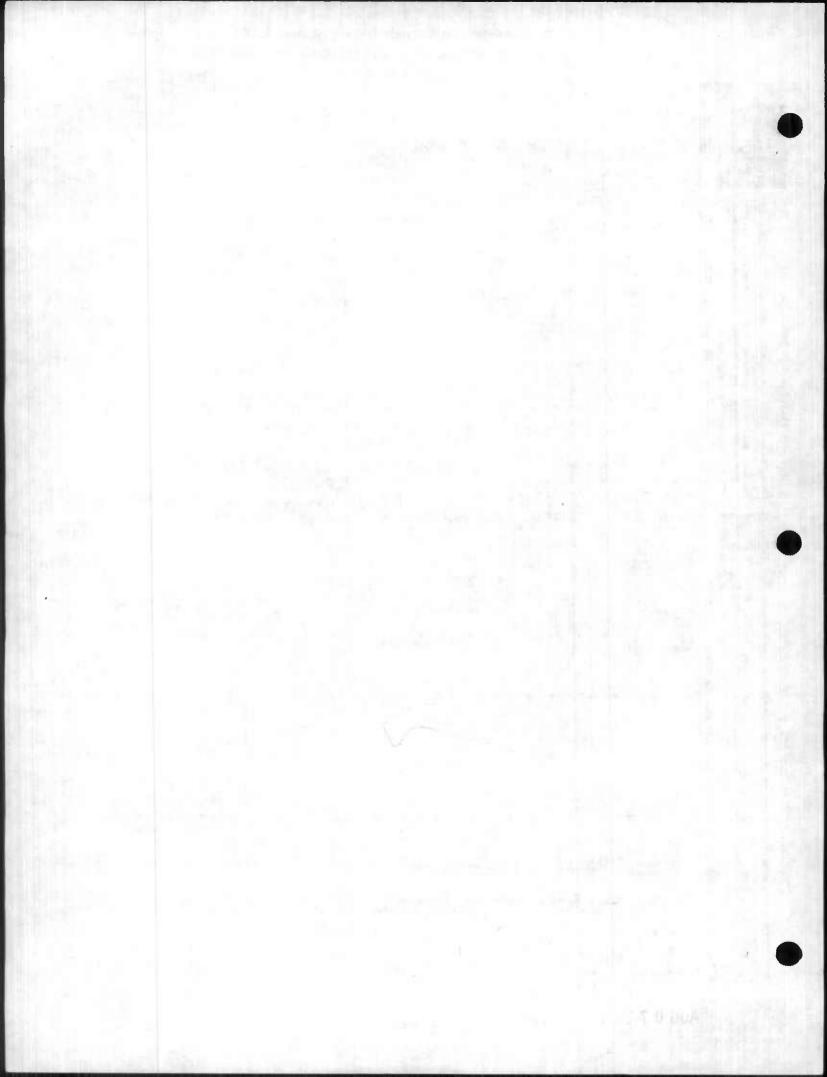


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Amedded items#19b &20c per FH g786 State of Maryland / Department of Health and Mental Hygiene 0 2 4 7 3 9

amend item 10c per fh G786 8/7/00 vg

	amend Ite	n T	oc bet 111 9,00 01,100	ув	Cert	ificate of	Death		R	eg. No.			
			1 Decedent'a Name (First, Migdle, La	st)		111		2.	Dete of Deel	4	M	3. Time o	Death
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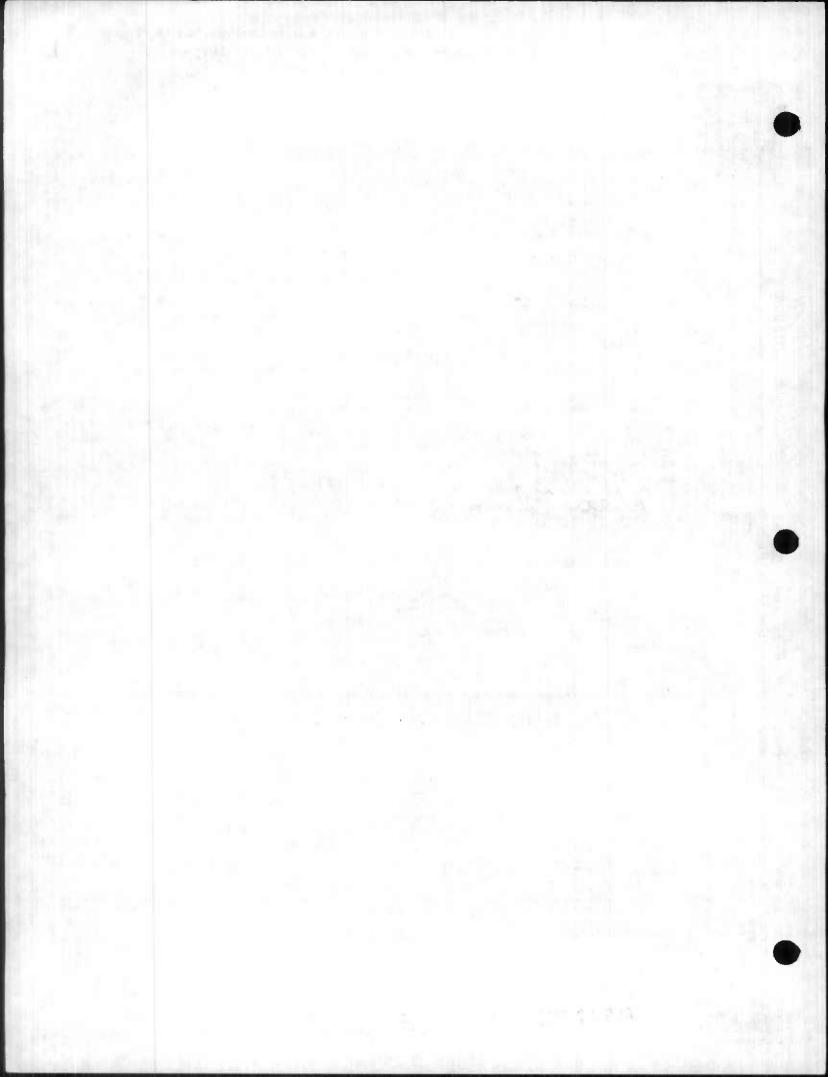


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State Registrar

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene 24741 Certificate of Death 2. Date of Death

Physician
/Medical
Examiner

Funeral

Director 28a-f ahow 8 238 Heme 6 "natural".

Director

Funeral

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Completed

with the Maryland treumetic event, the Medical Examiner must be notified at filed within 72 hours after death al Hygiene. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Nem 27 Is marked other any Injury or other trauments.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

P.O. Vital erone 8

89 To the Hospital within 24 hours a To the Funeral C

Completed by Physician/Medical Examine

To

Medical Certification:

State Registrar

3. Time of Death 1. Decedent's Nama (First, Middle Last) 2000 05:18 AM Jerome Dean JULY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore St Agnes Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10-31-1943 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days 1 Ø M 2 □ F 212-40-1268 56 Yrs. Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2000 McCulloh Street 21217 US A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Raca - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Fisher Body Auto Plant Elementary/Secondary (0-12) Coltega (1-4or 5+) 9th grade N/A Assembly Worker 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dean Hattie Mills 19a. Informant's Name/Relationship (Type, Print)Brother 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Bishop William E. Gaines, Jr 1907 Penrose Avenue Baltimore, Md 21223 20b. Place of Disposition (Nama of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Buriat 2 Cremation 3 Ramovat from State 4 Donation 5 Other (Specify) Western Star Cemetery 8-7-00 Catonsville, Md 22. Name and Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 is that caused the death. Do not unfor the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death immediate Cause (Final disaasa or condition rasulting in death) MYDO Due to (or as a consequenca of) Due to (or as a consequence of) Dua to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hologothy, reno

23b. Did tobacco use contribute to the cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 3 Probably Unknown

1 Tas

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case refarred to medical 26. Placa of Daath (Chack only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas No

28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation Natural 2 Accidant

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. tnjury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifier

3 Suicide

29a. Cartifier

4 Homicide

29c. License numbe

29d. Date signed (Month, Day, Year)

Nama and address of person who completed cause of daath (Item 23a) (Type, Print)

54

NC 15000

10015 Registra ' Signature 2000

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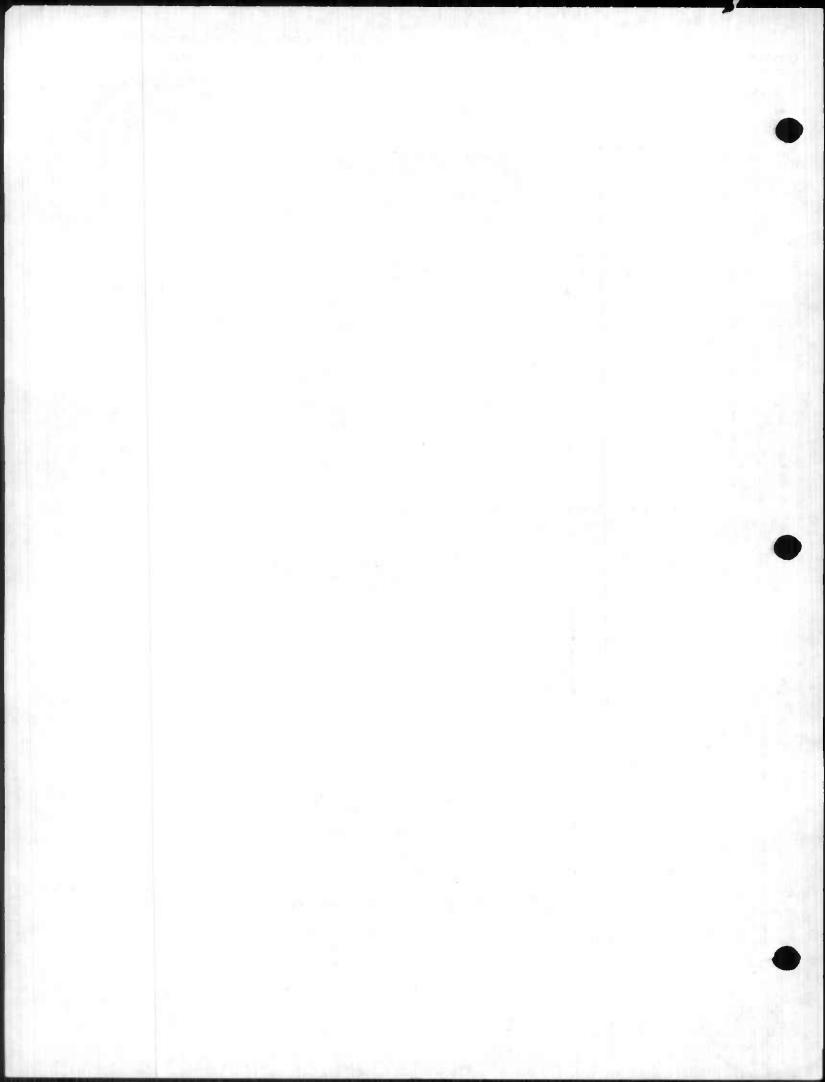
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DWARDS		State of Mary		ertificate of		, ,	eg. No.	0 24712		
DOM:	1. Decedent's Name (First, Middle, La.	st)				2. Dete of Deet Month	h	3. Time of Death		
Physician /Medical	Conrath	Edwar	rds				01, 200			
Examiner	4e Facility Neme (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death	4c. County o	of Death		
	1627 MONTPELIER	STREET			BALTIMO	RE	NA			
Funeral Director	5. Sociel Security Number 6. S 234-30-0213 Usuel Residence of Decedent	7. Age (In)	yrs. last birtho	Months Days				9. Birthplece (State or Foreign Country) W. VA.		
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Vision Attending octor: Afte by the fune	Suicide 6 Could not b	9 200 6100	At home, ferm	, street, lactory, office		281. Location (S	treet end Numb	er or Rurel Route Number,		
Division of the or Attending P as efter deeth. el Director: Aftertied in by the funers Certification:	4 Romicide	building, etc. (Sp	ecity A	Homes		16 25 Town	n, State)	8 2120		
ours series	29e. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, d	eeth occurred at the t	ime, date end pled	a, end due to the c	euse(s) and ma	nner as steted.		
Division o To the Heapital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7		niner: On the basis of examend menner steted.	ninetion and/o	or investigation, in my	opinion, death occ	urred et the time, d	ate end pieca, e	and due to the ceuse(s)		
Ne the	29b. Signature and title of certifier	^		29c. Licen	se number	2	9d. Date signed	(Month, Day, Year)		
) X'S	30. Name and address of person who	evy	(Itam (22c) (T		ME		AUGUST	02, 2000		
12 12	30. Neme land address of person who	completed cause of deeth (Penn Stre	et. Balt	imore. Ma	arvland	21201		
State	31. Dete filed (Month, Dey, Year)	32. Registrer's S	igneture	1.	1. 1		- Janeary			
Registrar	f.UG	7 2008	Graner	P/	goods					
DHMH 16 Rev 6/95		- 0001								

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 24743 Certificate of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** GEORGE J. FOWLKES JR JULY 30, 2000 1:55 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)

Min. (Month, Dey, Yeer)

1923 2606 Dennison Street N/A 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F 76 216-16-0899 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 21216 IISA 2606 Dennison Street death Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black White, etc. Pages 1 end 2 should be filed within 72 hours after inent of Health end Mentel Hygiena. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 black Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) warehouse foreman spice 7 is marked other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be George J. Fowlkes Sr. Helen Epps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) other t Bessie Fowlkes/spouse 2606 Dennison Street Baltimore, MD 21216 20b. Placa of Disposition (Nema of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Page Department of important: if eny Injury or pncs. 4 ☐ Donation 5 🖔 Other (Specify) in state 21. Signature of Funeral Service Licensae Ronald S Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line. leel Baltimore, MD Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CANCER WITH METASTASIS /Medical Examiner Dua to (or as a consaquanca of): Examiner MALNUTRITION Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last physicien end s the burial-tran Due to (or as a consequence of): certificate be axed NEMIA Box 68760 Physician/Medical the Due to (or es e consequence of): 98 RSA ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. the signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wera eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy peen has 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate f or Attending Physician; after death. Director: After this certific director, Be 25. Was casa rafarred to medical examiner? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 Yes 2 No 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 ☐ Homicide Hospital 24 hours a Funerel D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of cartifier Kholehm MZ D32700 01 2000 30. Name and addrass of person who complated causa of daath (Item 23a) (Type, Print) 821 N. EUTAW ST. BALT MD2120 KHOKHAR MD

32. Resistrar's Signature

Registrar

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24744 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Year **Physician** 5:50 AM Mary Josephine Felmey UGUST 2000 /Medical 4b. City, Town or Location of Deeth 4e Facility Neme (ff not institution, give street and number) 4c. County of Deeth Examiner GLEN BURNIE ANNE ARUNDEL ARUNDEL HOSTITAL NORTH If Under 1 Year If Under 24 Hrs. Bir hpiace (State or Foreign Country) 5. Social Security Numb 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 2☐¥F Months Deys Hours 220-07-1613 87 Yrs. Director Italy Usuel Residence of Decedent 10s. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Glen Burnie Anne Arundel Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ð Items 23a U.S.A 21061 213 King George Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 子ELMEY, MARY Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) I Hygiana. other than Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be and Mental marked 10 Josephine Battaglia Rosario Battaglia 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 2 213 King George Drive Glen Burnie, MD 21061 Alvin Felmey/ Husband Department of Health reportant: If Item 27 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 08-08 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ò 2000 Baltimore, MD New Cathedral 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Singleton Funeral Home P.A. 1 Second Ave. S.W. Glen Burnie, MD 21061 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximeta Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner Sequentially list conditions, if eny, laeding to immadiata cause. Enter Underlying Cause (Disease or injury Congest we Wear attending physician 68760 Physician/Medicai thet initieted events rasulting in death) Last Due to (or es e consequence of): as the Box usa P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown 3 signed b Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed has 1 Yes 2 No 1 Yes 20 No certificate of Vital 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA Aftar this 28e. Data of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending invastigation after deeth.

Director: Aft
d in by the fur 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di complataly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Pgint) Server Glen Burnie 2106)

Registrar **DHMH 16 Rsv 6/95**

31. Dete filed (Month, Day, Year)

AUG 0 7 2000

32. Registrer's Signeture

ORIGINAL

realization but to the state of the

State of Maryland / Department of Health and Mental Hygiene 24745 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month Physician 4, 7:00 AM 2000 Edna Evelyn Goldsmith August /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Lodge Senior Center
5. Social Security Number 6. Sex Anne Arundel Pasadena Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 KF Director July 7,1912 216-32-6350 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 ▼ No Director Carroll Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of Whal Country? USA 205 St. Mark Way Apt. 309 Funeral 21157 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 [Ži No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Stelus Bleck, While, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hyglene. Importants if Item 27 is marked other than "na any injury or other treumatic avent, the Mental page. Elementery/Secondery (0-12) College (1-4or 5+) Board of Education Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna Marshall Clarence W. Lockard 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Michele Gustaitis 704 202nd Street, Pasadena, MD 21122 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 Burial 2 Cremation 3 Removel from State 8/7/2000 Reisterstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) All Saints Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road time 21136 Reisterstown, MD Eline Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respirelory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Betw Onset and Death Physician Immediete Cause (Finel disease or condition resulting in deeth) /Medical Heart ta, lune Examiner abetes Examin physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enler Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, 8 Physician/Medical Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes 1 Yes 2√No 1 ☐ Yes 2 ☐ No certificate of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 20 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify Andrew Ly) 7 this 28a. Date of Injury (Month, Day Year) 27. Menner of Death
1 Selection 1 Selection 2 Accident 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: After Division or Attending 5 Pending investigation To the Hospital or Attanding within 24 hours after deeth.

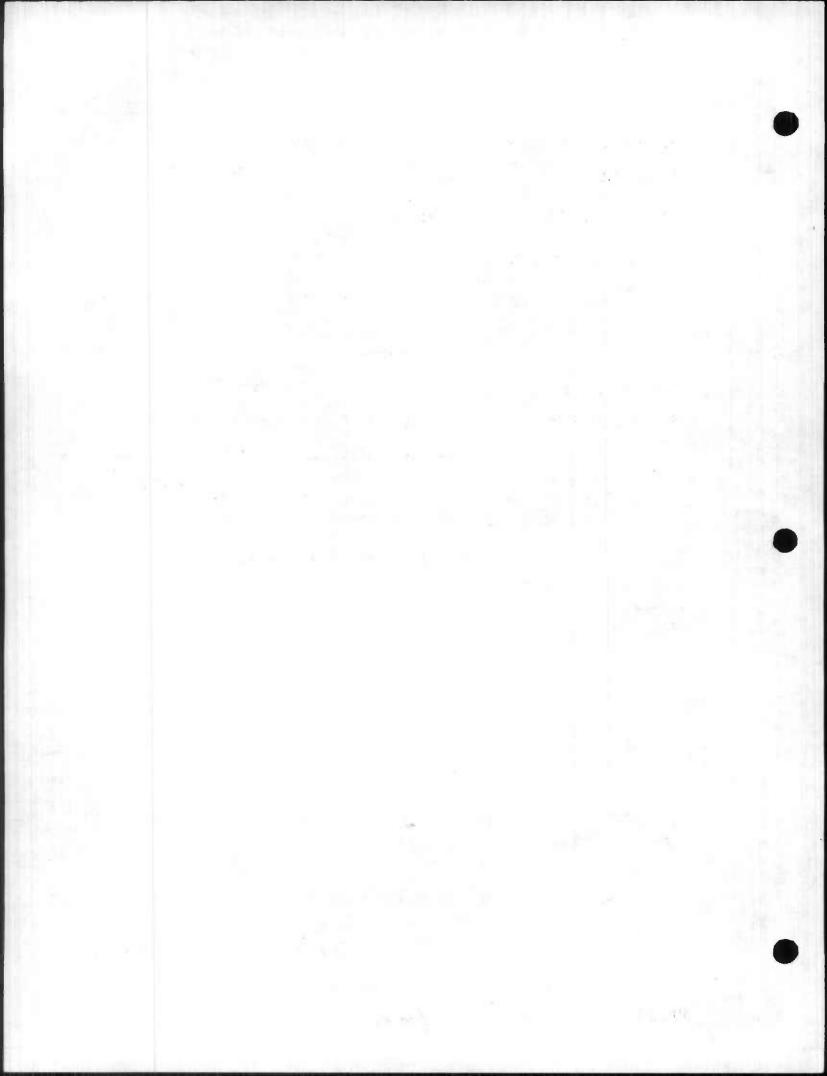
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 028686 Mon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor Playner MD. 1509 City Ritchie Hybry Arnold MO 21012 1509 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 0 7 2000

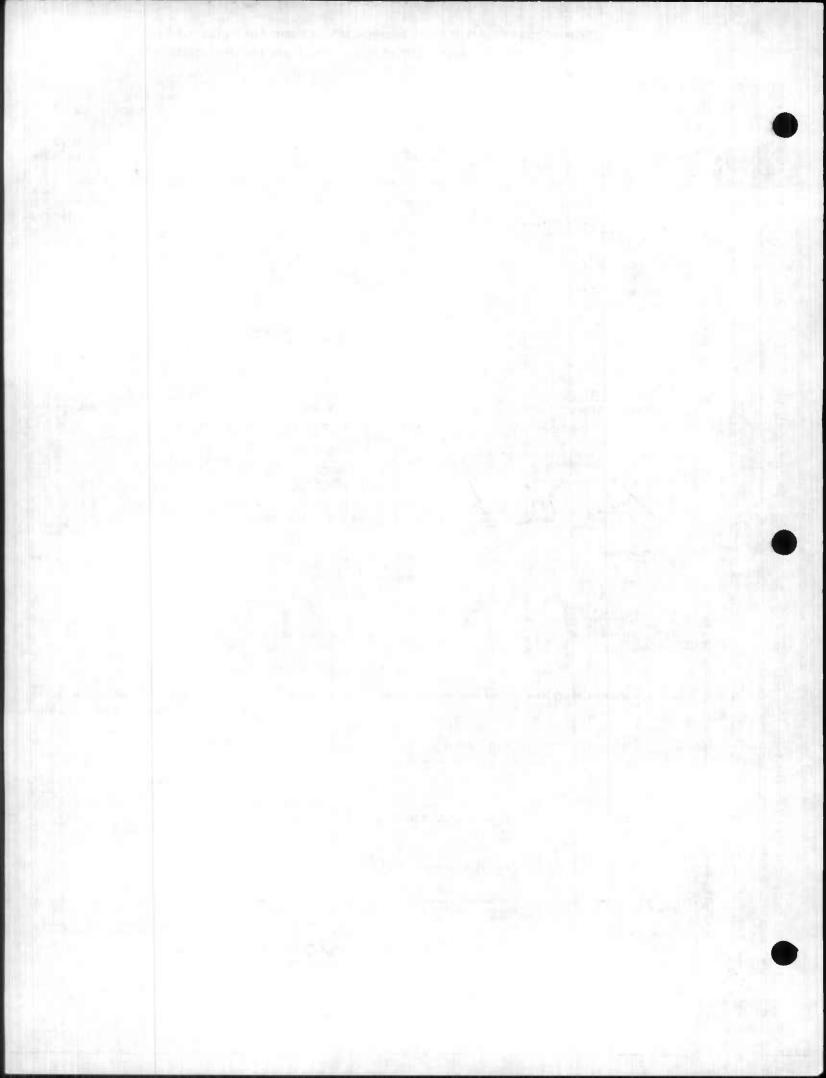


State of Maryland / Department of Health and Mental Hygiene 24746 Green Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** r Sr. August
4b. City, Town, or Location of Deeth 0350 Greer Sr. 2000 John /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner Pikesville Baltimore Co. Pikesville Nursing Home If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 1 M 2 □ F Yrs. **Director** S.C. 251-16-6700 Usuel Residence of Decedent 80 the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Randallstown MD Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. Funeral 3827 Brenbrook Drive filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. M Yes 2 □ No If Yes, Giva Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Federal Government . Pages 1 and 2 should be filed w transfer of Heelth and Mental Hygier tant: If them 27 is marked other th lury or other traumatic event, the 12th grade na 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Beatrice Crawford William Greer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19e. Informant's Neme/Reletionship (Type, Print) 3827 Brenbrook Drive, Randallstown, Md Velma G. Greer-Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Y Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or pace. Garrison Forest Vet. 8/7/00 Owings Mills, 21. Signeture of Funerel Service Lie March F/H West ala 4300 Wabash Ave, Baltimore Md 21215 thans that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, cause on each line. Approximate tntervel Between Onsat and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only **Physician** Immediata Causa (Final diseese or condition resulting in deeth) /Medical 4-ears Examiner Dua to (or es a consequence of Physician/Medical Examiner The law requires that the death certificate be axecuted usa es the burial-trans Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. thet initieted events resulting in death) Last Due to (or es e consequence of): P.O. Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed by by of Vitai Records, 24b. Were eutopsy findings availabla prior to completion of causa of deeth? page 2 should Be Completed 24e. Wes en eutopsy performed? this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No hal or Attending Physician: The safar deeth.

al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Maturel Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

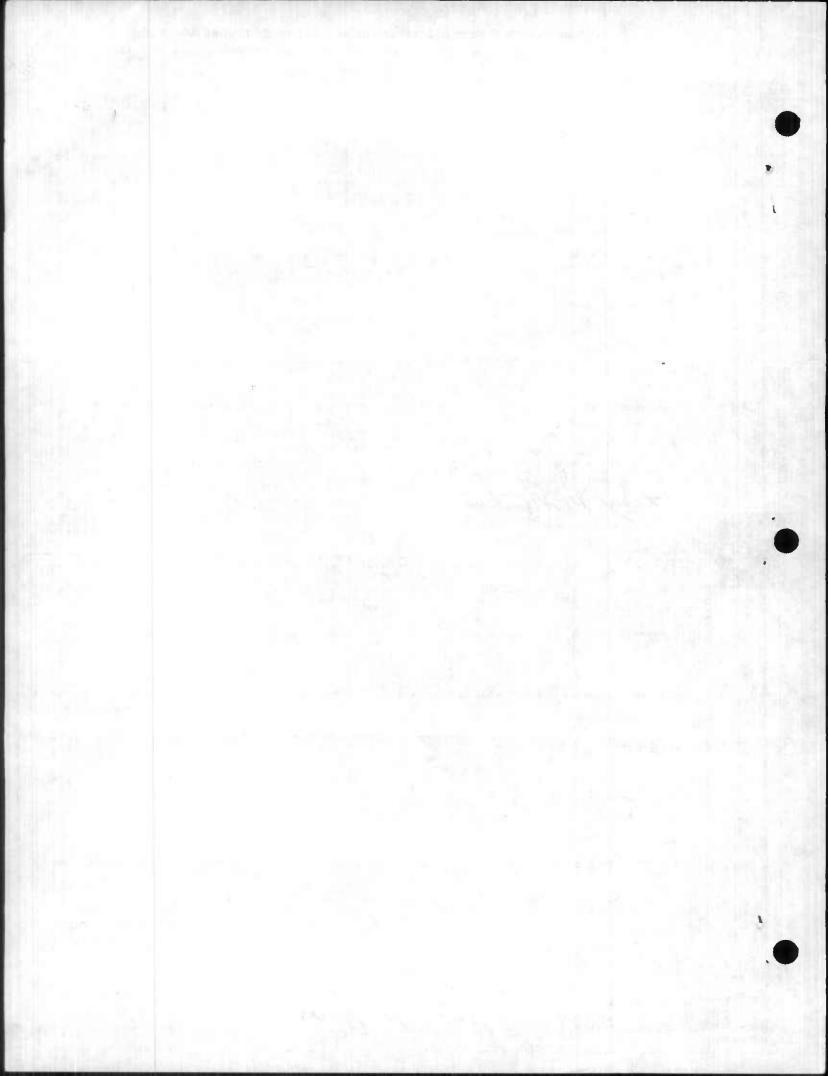
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number D37573 1,7000 41 0-30. Name and address of person who completed eduse of death (Item 23e) (Type, Print) 3 Battimere MD IRF CIDEN MD Park Ave 7220 21708 31. Data filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 7 2000 OBERRA

Registrar



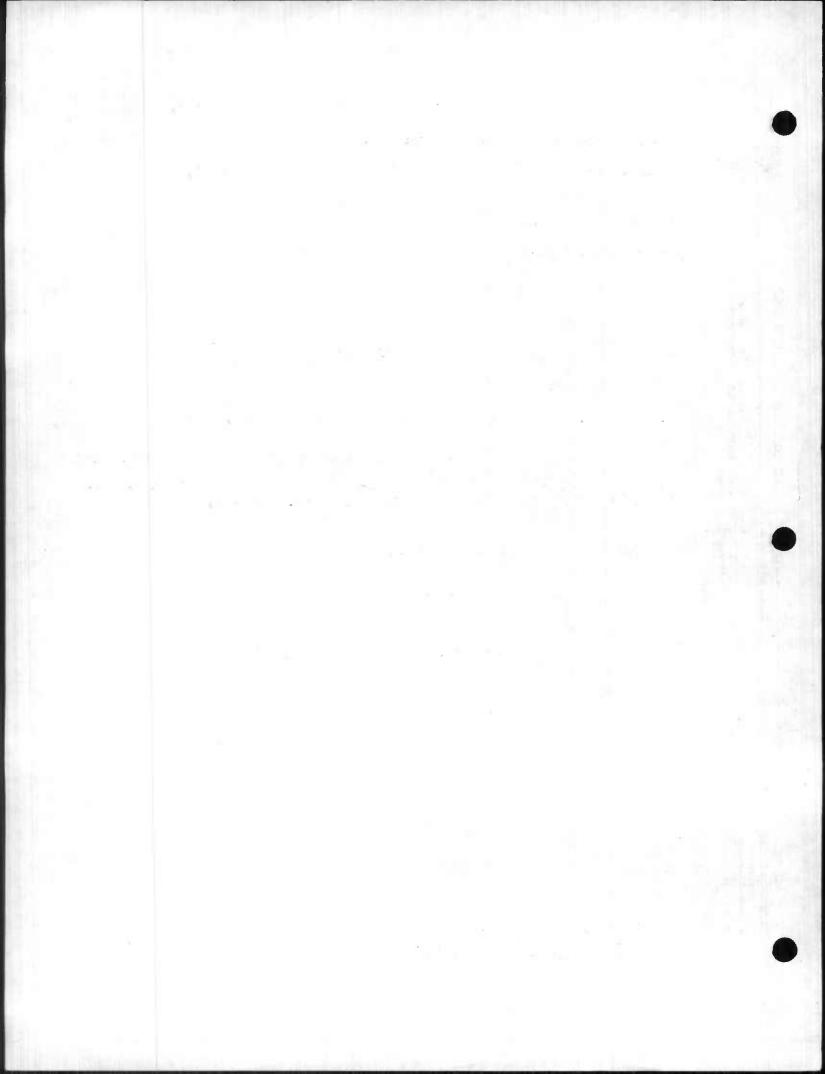
State of Maryland / Department of Health and Mental Hygiene 00 24747

				Certifica	te of	Death		Re	g. No.		
Physician /Medical	Decedent's Neme (First, Middle, Last Pear1	C .	G	oldste	in			2. Dete of Death Month August	Dey	2 0 0 0	3. Time of Death 6:40A.
Examiner	4e Facility Name (If not institution, given Washington Advent	street end number tist Hosp	ital			4b. City, Too Takoma		ation of Death	4c. County Mont	of Deeth	Y
uneral Director	002-20-0133	ex 7. A	ige (In yrs. lest birl	hdey) If Und Month	er 1 Yeer Deys		Min.	8. Dete of Birth (Month, Dey, Peb. 10, 1	Year) 934	9. Birthpi Coun. New Y	lece (Stete or Foreign try) O rk
r 28a-f show incurred at frector	Usual Residence of Decedent 10e. Stete 10b. County Maryland Prince (George's	10c. City, Town							10	0d. Inside City Limits XXYes 2 □ No
r tema 23a or 28a-f s instrument or course Funeral Director	10e. Street and Number 6Y Plateau Place			10f. 2	ip Code 207	770		10	g. Citizen of ' Unit	What Coun ed St	
by	11. Meritel Stetus 1 Never Merried 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes XX If Yes, Give Yeer or Detes	?] No			Hispanic Original Mexican Specify:	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)		ce - America ck, White, o	
r, tre Macrel	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12)		(5+)	Decedent's Us (Give kind of v life. DO NOT Cretary	rork done use retire	petion during most ed)	t of workin	g 1	6b. Kind of B		
Be	17. Father's Neme (First, Middle, Last) Herman	Rosen		crecary			or's Name	(First, Middle, M		ne)	ınkown)
tracum	19e. Informant's Name/Relationship (1991) Melvin Goldstein			Meiling Addre			er or Rurel	Route Number,	City or Town	Stete, Zip	Code)
ry or other tr	20e. Method of Disposition 1 Striat 2 Cremetion 3 Classification 4 Donation 5 Other (Specify		e	Disposition (Ny, cremetory of Memori	other pie		8/3		Oc. Location		
bunal-trensit up p u p u lury lury lury lury lury lury lury lu	23a. Pert1. Enterine disease, or compshock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	olications that causone ceuse on each	ed the deeth. Do reline. Myoca Due to (or es a coscleros Due to (or es a coscleros	4400 F ot enter the more rdial	Powde of dy Inf	er Mili	l Rd.	Funeral Beltsv respiratory erre	ille,		and 20705 Approximate Intervel Between Onset and Death 2 minute years
Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	tes Mell Due to (or es e of	onsequence of							years
tached for use	Pert II. Other significant conditions of	ontributing to death	but not resulting tr	the underlying	cause g	iven in Pert I					the cause of death?
page 2 should be detached for us Completed by Physician/	renal failure Pulmonary insuff	iciency						24e. Wes er	eutopsy	24b. We	ere eutopsy findings eilable prior to mpletion of cause
page 2								1 ☐ Ye	s 2 No		deeth?
by the funeral director tiffication: To Be	25. Wes case referred to medicel examiner? 1 Yes 2 TNo 27. Manner of Death 1 Maturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined	28e. Plece of I	- ,	tpatient 3 lime of njury M	28c. tnju Wo	ther: 4 Nu liny at ork? Yes 2 I	rsing Hom 2 No	(Check only one 5 Reside 8d. Describe ho 8f. Location (Str. City or Town	nca 6 Ott	rred	y) il Route Number,
pletely filled in b edical Certif		ysician: To the bes	t of my knowledge	, deeth occurre	d et the t	ime, dete en	d plece, a	nd due to the ce	use(s) end m	anner as si	teted.
Medi	29b. Signature and title of certifier	end menner s	steted.			se number			Augus	ed (Month,	Dey, Year)
15	30. Name and eddress of person who of Sridhar Chatrath.				oad.	#302	Lanh	am, Mar	vland	20706	



State of Maryland / Department of Health and Mental Hygiene 00 24748

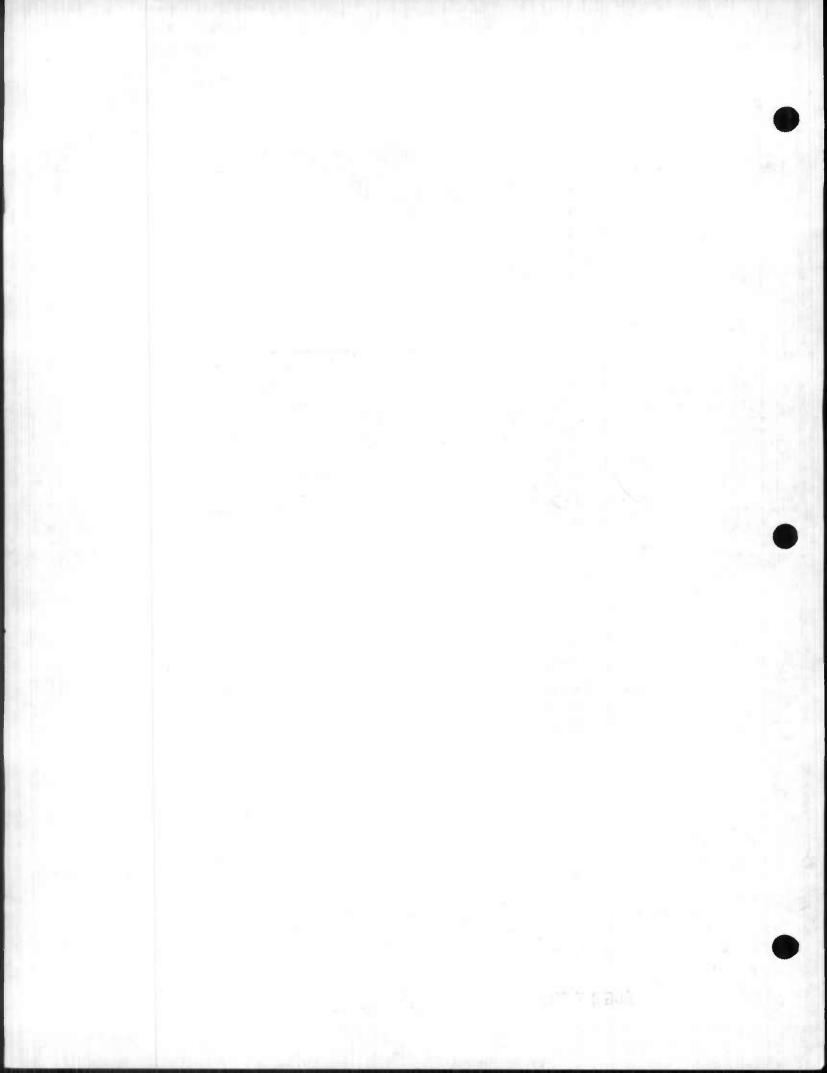
					Certificate of			ng. No.	24140
Di	nysician	Decedent's Neme (First, Middla, La.					2. Date of Death Month		3. Time of De
100	Medical		Thomas	R.	Gajewski		August	3, 2000	1 / 1 / 1
	xaminer	4a Facility Neme (If not institution, give	a street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of	Death
1		Genesis Heritage				Dunda1		Balti	more
Dire	neral ector	5. Social Security Number 6. S 217–18–1687 Usuel Residance of Decedent	ax 7. Age (In ☐ M 2☐ F 76	yrs. last birth Y	Months Deys	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, April 3		Birthplace (State or Fi Country) laryland
dend dend	t u	10a. State 10b. County	10c	City, Town	or Location				10d. Inside City I
Men	to a	Maryland	N/A			Baltimore	City		NEXYes 2
deeth with the Meryland	9	10e. Street end Number		-	10f. Zip Code	DOTOTHOLO		g. Citizen of Wh	et Country?
Will San	1 0	6611 Bushey St	reet			21224	1	United S	tates
9 4	leted by Funeral Director	11. Marital Status 1 Never Merried 24 Married 3 Widowed 4 Divorced	12. Was Decedant Evar Armed Forces? 1 □XYas 2 □ No If Yas, Giva Yeer or Detes: 7.7		13. Wes Decedent of H ff Yes, specify Cub- 1 ☐ Yes 2KNo		ecify Yes or No- Rican, etc.)		American Indian, White, etc.
2 2 0	1 P	15. Decedent's Ed	lucation	WII 16a. E	Decedent's Usual Occup	pation	1	16b. Kind of Busi	
21215-0020 d within 72 hours at giene.	r, the Medical	(Spacify only highest gra Elementary/Secondary (0-12) 12 Years	de completed) College (1-4or 5+)	(Giva kind of work done life. DO NOT use retire Mill Wright	d)	ing	Stee1	Industry
D PE	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M		
/aud by Alente A	To	Thomas Gajewsk	i			Helen	Fabizak		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	5	19e. Informant's Neme/Reletionship (19b.	Mailing Addrass (Street	and Number or Rura	al Routa Number,	City or Town, St	ate, Zip Code)
and and	5	Mr. Ronald T. Ga	jewski (Son)	9	122 Avenue	B Edgeme	ere, Mar	yland 2	1219
Baltimore, Maryland 212: pemit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than	ry or oth	20a. Method of Disposition Y☐Burial 2 □Cremetion 3 □ 4 □Donation 5 □ Offer (Specific	Ramoval from Stata	cemetary	Disposition (Nama of crematory or other place) ROSARY Cemet				ty or Town, Stete
Balti pemit. Departm	any inju	21. Signeture of Furnish Service Licen	Il)	/	22. Neme end Addre Duda-Ruck 7922 Wise	Funeral I	Home of	Dundalk,	Inc.
Physi		23e Part. Entar tha diseese, or com shock, or heart failure. List only	plications that curised the cone ceuse on such lina.	leeth. Do no	ot enter tha mode of dyir	ng, such es cardiac d	or respiretory erra	st,	Approximate Interval Batwee Onset and Dea
/Med Exam	_	Immediate Cause (Final disease or condition rasulting in death)	a		ctery Dise	ease			15 year
70	Je			20.77	of Liver				10 ,,,,,,,
cute	rens me	Sequentially list conditions,			onsequance of):				10 year
, a a a a a a a a a a a a a a a a a a a		Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Diseesa or Injury that initiated events	Diabet	es Me	ellitus				15 year
	sa as the bural-transit Medical Examiner	thet initiated events rasulting in death) Last			nsequence of): Vascular	Disease			10 year
BOX eath cert	for usa								
) å å	Physician/N	Part II. Other significant conditions of	ontributing to death but not	resulting in	the underlying cause given	en in Pert I.	23b. Did tol	bacco use contr	ibuta to the cause of d
S, T, S thet t	2 5	Benign Pro	state Hype	rtrop	ohy		1 Ye	98 2□No 3	Probably 4X Un
	shou						24a. Wes an perform		24b. Were autopsy find eveilable prior to completion of caus of death?
ate h	I director, page 2						1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No
olan:	Be (25. Wes case referred to medical examinar?				26. Place of Death	Check only one	a)	
n Of VITA g Physician: terthis certific		27. Mannar of Deeth	Hospital: 1 ☐ Inpatient 28e. Dete of Injury (Month, Dey Yea.	28b. Ti	ne of ury 28c. trijur	4 Nursing Ho	me 5 Reside 28d. Describe ho		
Attending or death.	he fu	1 Neturel 5 Pending investigation				Yes 2□No			
DIVIS all or Atte	led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - A building, etc. (Sp	t home, fem	n, street, fectory, office		28f. Location (Str. City or Town		or Rural Route Number
To the Hospital o within 24 hours at To the Funeral D	completely filled in Medical Cert	29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ystctan: To the best of my ilner: On the basis of exam and mannar stated.	knowledge, ination and/	deeth occurred et the tir or investigation, in my c	me, deta end place, opinion, deeth occurr	end due to the ca ed et tha tima, da	usa(s) and menr ita and place, an	ner as stated. d dua to tha cause(s)
o thin	Me	29b. Signeture and title of outsing	1.0		29c. Licens	e number	29	d. Dete signed (Month, Day, Year)
1	١	· gravy	5 1 Mg	an	. D0	014160		08/0	4/00
	v 9	30. Neme end address of person who o	completed causa of death (Item 23a) (T	ype, Print)				
	· 1	Harjit Singh	M.D. 54	10-A	Ritchie	Highway_	Baltimo	ore, Mo	21225
Re	State egistrar	31. Data filed (Month, Dey, Year) AUG 0	32. Registrer's S	gneture		47			



State of Maryland / Department of Health and Mental Hygiene

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)	2	4	1	4	9

	Ameded ite	emi	16a per FH G786 8-7	-00 wjj		Cert	tificate d	of Death		Reg. No.		-7172		
			1. Decedent's Nama (First, Middle, L		-				2. Data of Dea	ath Day	Year	3. Time of Deat	h	
. 6	Physician /Medica	_		Percy	Hin	nton, J	r		July		2000	5:10 P.I	М.	
	Examine		4a Facility Nama (If not institution, g					4b. City, Town, or I				10.20 20		
			719 Park Avenue					Baltimo	re	1	I/A			
	Funeral				ge (in yrs.	last birthday)	If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	place (State or Fore	eign	
	Director		212-40-3093	1 M 2 □ F	58	Yrs.	Months Da	ays Hours Min.	(Month, Day	-1941	Cour	Md Md		
Н			Usuat Residence of Decedent							13 (1				
	anylan											10d. tnside City Lin	nits	
	Mary C	0	Md N/A Baltimore						1 ☐ Yes 2 ☐ No					
	vith the Mar	6	10e. Street and Number	FIRELA			10f. Zip Cod	de		10g. Citizen of V	Vhat Cour	ntry?		
	death with the Maryland rms 23s or 28s-f show rms to nother st	719 Park Avenue 21201 U.S.A												
	frar death v	-	11. Marital Status	12. Was Decedent		,S. 13. W		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yas or No			can Indian,		
0	flar har		XX Nevar Married 2 ☐ Married	Armed Forces	? No				o Rican, atc.)					
21215-0020	8 0 3	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Datas:	1 X Yes 2 □ No If Yes, Give 1 □ Yes 2 X No Specify: Year or Datas:			No Specify:		Specify	Blac	:k		
0	neture!"		15. Decedent's I	Education		16a. Decede	ent's Usual Oc	ecupation		16b. Kind of Bu	usiness/In	dustry		
215	nin 7.	Completed	(Specify only highest g		e.\	(Give k	ind of work do nayman	one during most of wor stired)		Destan	.+	and domain		
217	within jiene.		G E D	College (1-4or	5+)	D	L - D	esidences	te	PILV	ate re	estdence		
D	be filed htal Hygin d other event,		0	17. Fathar's Nama (First, Middla, Las	it)					ne (First, Middle,	Maiden Sumen	ne)		
an	Dad o	0	Percy Hintin, Sr					Mary C	arter					
2		- -	19a. Informant's Name/Retationship	(Type Print)		19h Mailine	Address /St	reet end Number or Ru		er City or Town	State 7ir	a Code)		
Maryland	d2:		David Shapiro- L					1 Street S					22	
	f Heal f Heal other	-	20a. Method of Disposition	awyer	20b. F				Date Date	20c. Location -		, Md 2120	12	
0	or of the		1X Burial 2 ☐ Cremation 3			Place of Dispos semetery, crem								
Ħ	tment tant: I		4 Donetion 5 Other (Spec		Gar	rrison l			8-4-00	Owings	M1111	s, Md		
Baltimore,	permit. Page: Department of Important: If i any injury or ance.		21. Signature of Funeral Service Licansee 22. Name and Address of Facility											
-	90F 9 9		March F/H West 4300 Wabash Avenue Baltimore, Md 21215											
	11111		23a. Part1. Enter the disease, or con	mplications that causa	d Ne daat	h. Do not anta	r tha mode of	dying, such as cardiac	or raspiratory a	rest,		Approximate Intervat Between		
	Physician	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Blunt Force Injuries of Head, Stab Wound of Chest,										Onsat and Death	1	
4	/Medical		Immediate Cause (Final			_	es or	Head, Stat	wound o	or Chest				
	Examiner		disease or condition resulting in death)	a. And Str										
Ш		0	Due to (or as a consequence of):											
	ned insit	b												
	be executed ician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Cause (Disease (Disease (Disease or Injury Cause (Disease												
68760,														
587	ficate be physicials the bu		resulting in death) Last		Due to (o	r as a consequ	enca of):							
	ding plant p	2		d										
Box	death cer e attendin d for use	181												
o.	ed by the detached	Physician/M	Pert II. Other eignificant conditions	contributing to death I	but not res	ulting in the un-	derlying caus	e given in Pert t.	23b. Did	tobacco use co	ntribute t	o the cause of de	ath?	
0	d by								10	Yee 2X No	3 Pro	bably 4 🗆 Unkr	nown	
5,	8 68	2							-41	1 months	T 0.45 141	face and an ending street		
Records,	The law requires sate has been sign page 2 should be	3							24a. Was perfo	an autopsy med?	av	ere autopsy findin- vailable prior to empletion of cause		
G	aw 2 sl	101									of	death?		
	The la	5							1₩	Yas 2□No	1	⊋Yes 2□ No		
Vital	certificate har rector, page		25. Was case referred to medical					26. Place of De	eth (Check only o	ne)		N.		
>		5	axaminer? 1 💢 Yes 2 🗌 No	Hospital:	ient 2	ER/Outpatient	3ET DOA	0.1			er (Speci	wat scen	_	
o o	rthis eral di		27. Manner of Death	28a. Date of this	ury	28b. Time of	28c.	tnjury at Work?	28d. Describe	how injury occur	red Sti	biect wa	S	
0	other : After e funer		1 ☐ Natural 5 ☐ Pending investigati	Found	2000 F	Found:	M 1	Work? 1 ☐ Yes 2 No	struck	28d. Describe how injury occurred Subject was struck, stabbed, and				
S	death ctor: A y the f	2	3 ☐ Suicide 6 ☐ Could not	be 090 Pteen of In		5:07 F		fica	strang.	ation (Street and Number or Rural Route Number				
Division	tal or Attending P rs after death. al Director: After t led in by the funera		28e. Placa of Injury - At home, tarm, street, factory, offica building, etc. (Specify) Residence						City or To	vn, State) 719	Par	k Avenue	,	
	Hospital 24 hours Funeral itely filled	2	29a. Certifier 1□ Certifying P	thuslelen: To the best	of my kno			ne time, date end plece		ore, Mai				
	n 24 hour n 24 hour he Funer pletely fil	2	(Check only one) 2 Medical Exe	miner: On the basis of	of examine	tion end/or inve	estigetion, in	my opinion, deeth occu	urred et the time,	dete end plece,	end due t	to the cause(s)		
	To the Hospital or Attend within 24 hours after deal To the Funeral Director: completely filled in by the		29b. Signature and title of certifier	and manner si	aleG.	172	290 11	cense number	,	29d. Date signe	d (Month	Dav. Year)		
	5.358 _		200. Signature and title of certifier	111					171					
	1.6		Y/1.	- Con	173			O.C.M.E.		July 29	, 20	000		
	2 9	1	30. Nama and address of person who	completed cause of	death (Iter	n 23a) (Type, P	rint)							
			Mary G. Ripp	le, M.D.		111	Penn S	Street, Bal	timore.	Marylar	nd 21	201		
	State	,	31. Data filed (Man Gay (Year) 2	000 32. R	rar's Sions	sture 19	ppa			1				
	Registrar					/-	1900	The State of the S						

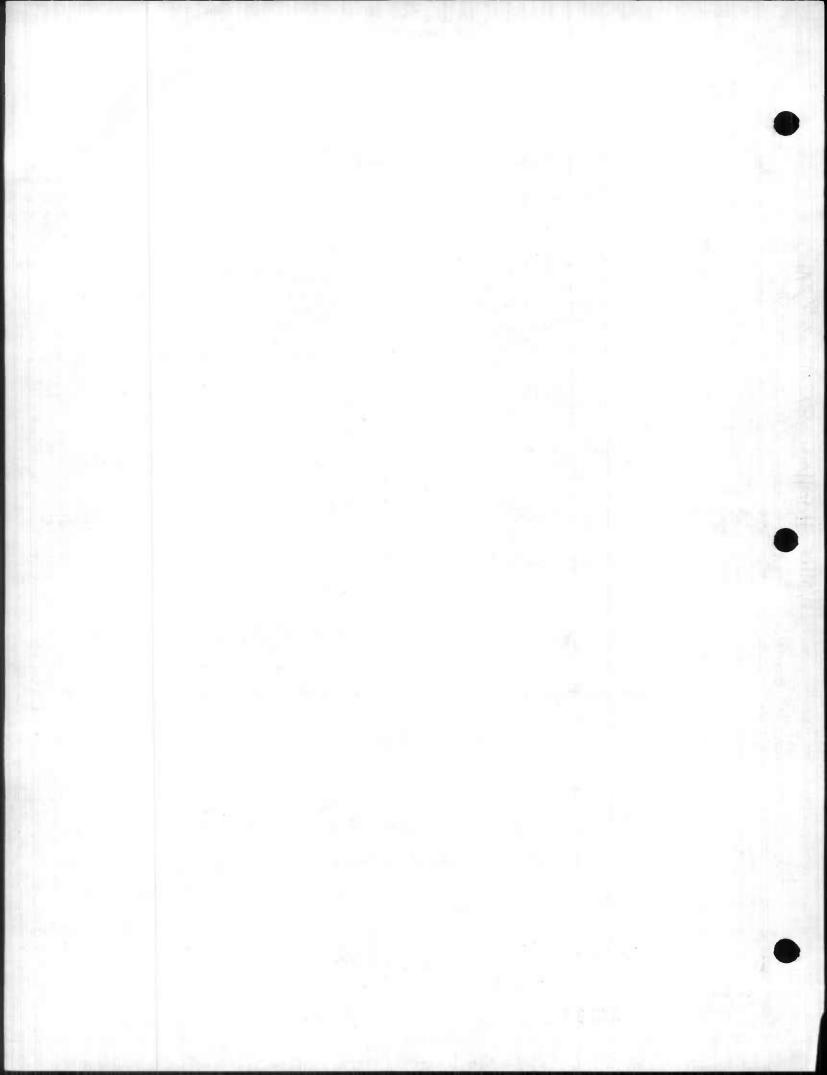


State of Maryland / Department of Health and Mental Hygiene

			State Of M	iai yiai				Death	a Wellal n	Reg	UU	1 2	4750
Physicia	an		Decedent's Name (First, Middle, Last)						2. Date of I	Death	Dey	Year	3. Time of Death
/Medic Examine		Wa 4a Facility Name (If not institution, giv	1ter L. H		ove			4b. City, Town, or Location of De			2, 2000 h 4c. County of De		6:30am
LAMININ	61	Joseph Richey H	ospice					Balti	more			N/A	
Funeral Director		217-38-1024	ex 7. A	ge (In yrs. 60	last birthday) Yrs.	If Unde Months	Deys	If Under 24 h	Irs. 8. Date of E (Month, I JULY	Day, Yo	1940	9. Birthp Coun	lace (Stete or Foreign try) yland
yand how		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
to Ma	cto	Maryland N/A			Ba	1time	ore						1 Yas 2 □ No
er death with the Marylar Herns 23s or 28a-f show Def.must be notified at	Funeral Director	1 000 G		001		10f. Zij				10g.	Citizen of W	/het Coun	try?
ne 23	era	1820 Spence Stre	et Apt.		IS 13 V	Was Dace		21230	(Specify Yes or I	Vn-	_	JSA - Americ	an Indien,
020	P	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yas 2 If Yes, Give Year or Dates:	?		Yes, spe		Specify:	(Specify Yes or I larto Rican, etc.)	10		k, White,	
21215-0020 d within 72 hours at plene. r than "natural", or the Medical Exem	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1.2	lucation de completed) College (1-4or	5+)	(Give	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired) OCIAL Security			16b. Kind of Business/Industry				
		17. Father's Nama (First, Middla, Last)			Soc	1a1 ;	secu		Name (First, Midd				vernment
Maryland 42 should be file h and Mental Hy lis marked othe traumatic svent	To Be	John A. Hart	love					Pe	arl L. S	and	er		
A sho	'	19a. Informant's Name/Retetionship (., .						Rural Route Num			Stete, Zip	Code)
C 2 64 F	-	Helen V. Mitchel	1/sister	20h I					anover,	7		Oite or To	- Ctata
Baltimore, semit. Pages 1 a Department of He mportant; if them iny injury or othe 2558.		20a. Method of Disposition 1 Burial 2 Cremation 3			Place of Dispos cemetery, cren				Dete		c. Location - (
Itin	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signeture of Funeral Sarvice Licen		Met	ro Cre	Mato:	d Addre	nc .	8/3/00		Balti	more	, MD
B F G G F G G		Cremation Society of Maryland, Inc.										20	
Physician		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate intervel Between Conset end Death											
/Medical Examiner		Immediate Cause (Final disease or condition END STAGE RENAL DISEASE 15 year											
182		Due to (or es e consequence of): HYPERTENSION											
uted d ansit	를												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. HYPERTENSION Due to (or es e consequence of): C. Due to (or as a consequence of):										1		
E 04	resulting in death) Last												
desth desth	Cla	Pert It. Other significant conditions or	ontributing to death h	out not res	ulting in the ur	ndertvina (eusa niv	en in Pert i	23b. Di	d toba	cco use con	tribute to	the cause of death?
	y Physician/M									Yes	2 X No		ebly 4 Unknown
of Vital Records, P.O. Box Physician: The law requires that the death cert this certificate has been signed by the attending	Completed by								24a. Wa	as en e	utopsy d?	ava	ore autopsy tindings hilable prior to inpletion of cause death?
The law ate has page 2									10	Yes	2 X No	10	Yes 2□ No
Vital I	B	25. Wes case reterred to medical examiner?	Mosnital:				04		Deeth (Check only	(Check only one)			
on of VIta ding Physician: h. After this certific funeral director.	tion: To	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation				28c. Injur	4 LI Nursin		Residence 6 Apther (Specify) HOSPICE ribe how injury occurred				
DIVISION or Attending a ster death. If Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	Place of Injury - At home, ferm, street, fectory, office 28t. Location					n (Street end Number or Rural Route Number, Town, Stete)				
Hospi 24 hou Funer tely fill	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	f axamina	wledge, deeth tion and/or inv	occurred	et the tin	ne, dete end ple pinion, deeth o	eca, end due to the courred at the time	e caus e, dete	e(s) end me and placa, e	nner es si and due to	ated. the ceuse(s)
To the vithin 2 To the comple	ž	29b. Signature and title of certifier	7			29	c. Licens	ense number			29d. Date signed (Month, Dey, Year)		
		- TKShelly	EMD D16402						August 312d, 2000				
6		30. Name and address of person who o	completed cause of a	death (Iten	n 23a) (Type, I	Print)	1.30	E BA	IT MD				
Stan		Y.KSHETTY 31. Date filed (Month, Day, Year)	300 /7KM			, de	1	11000	1,110	-12	~		
Registra	-	AUG 0 7	2000 17	eper	~ B	1	100	Ka					

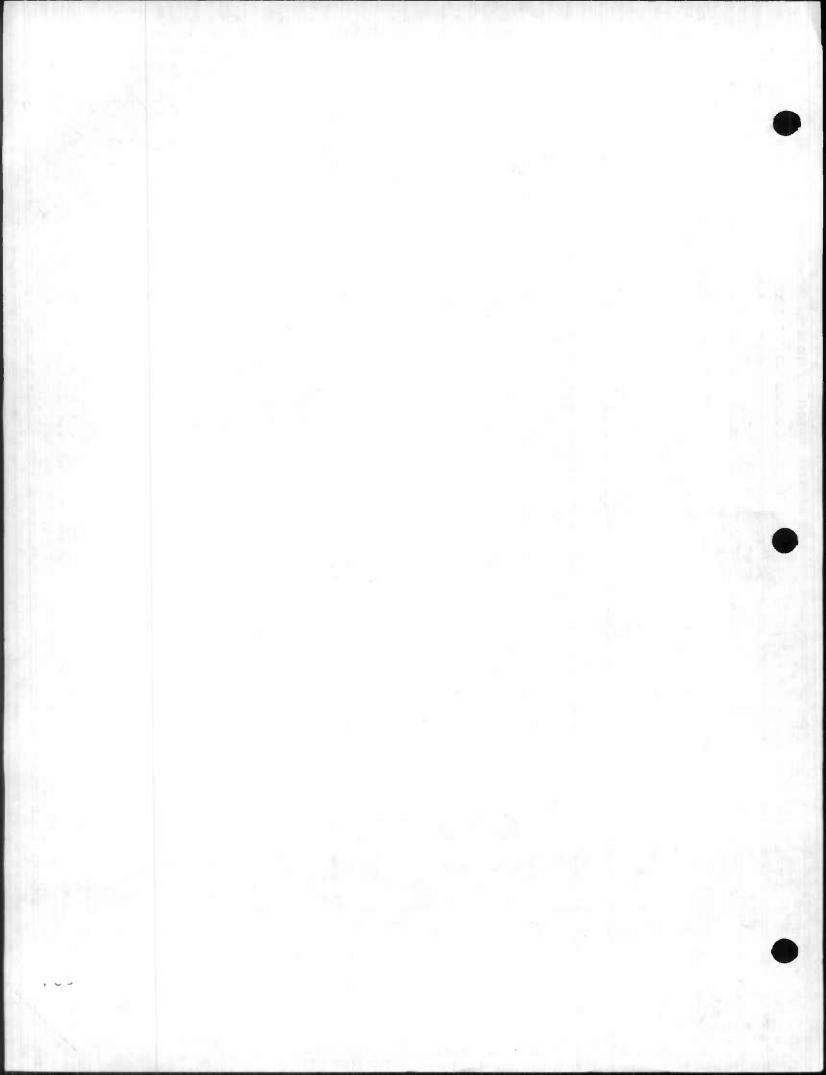
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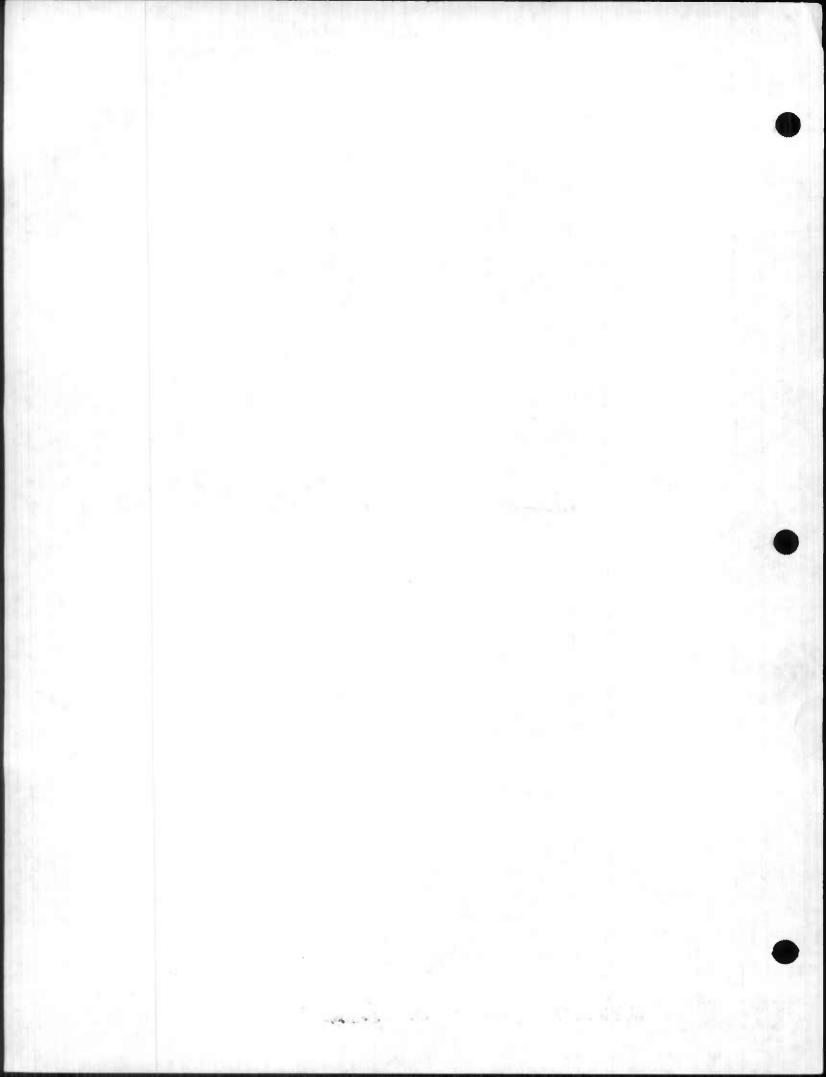


State of Maryland / Department of Health and Mental Hygiene 00 24751

				Ce	rtificate o	f Death	F	leg. No.	100 1 1 0 1			
	Physician	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th Day	Year 3. Time of Death			
	/Medical	nousden						420	100 854 pm			
	Examiner	Franklin Square	1 1 - 1				Baltimore					
	Funeral Director	5. Social Security Number 6. Security Number 15. Social Security Number 15. Security N	7. Age (h	yrs. last birthday, Yrs.	ff Under 1 Year Months Day			, Year) 1922	9. Birthplace (State or Foreign Country) WT.			
	9	Usual Residence of Decedent										
	with the Marylar as or 28a-f show be notified at Director											
	or 28a-1 a be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?			
	23e rai	6828 Broening R	d		2122			USA				
215-0020	ar, or hams Examiner in by Fune	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U,S. 13.	Was Decedent of If Yes, specify Control of Yes 20€N	f Hispanic Origin? (Suben, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - American Indien, k, White, etc. White			
9-0	72 ho fical i	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occ	upation	rking	16b. Kind of Bu	siness/Industry			
99	Wen's	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of wo red)	ixiig					
- 01	led within typiene. her then nt. the Me	8 yrs.		Pacl	aging	10 Matheda Na	me (First, Middle,	Steel				
yland	Mental Parked of stic ever	T-1-1-15 1-	TEN	5 6 5 19		Anna Py		Maiden Suman	9)			
Den, Mary	and 2 ah aith and 27 is m	19a. Intormant's Name/Relationship (Ty Bruce Housden	pe, Print) Son		-	et end Number or R W Valley			State, Zip Code) n, Md. 21009			
HOUS!	Pages 1. nent of He mit; if Berr ary or oth	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park 2000 Baltimore										
Balt	Departi Departi Importa any Inji	22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A.										
	2.851202.00	7110 Sollers Point Rd. Dundalk, Md 21222 23a. Perti. Enter the disease or complications that caused the deeth to not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										
	Physician	23a. Pert1. Enter the disease, or complications that caused the deeth on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death										
7	/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) 8 Days										
и.	je je	Due to (or as a consequenca ot):										
	entificete be executed ling physicien and se es the bunial-transit	Sequentially list conditions, Due to (or as a consequence ot):										
90,	Sien a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
68760,	ficete be physicie s the bu	Cause (Disease or injury that initiated events Due to (or as a consequence ot):										
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Bo	ettend for us								1			
0	thet the death certified by the ettending deteched for use a Physiclan/Met	Part II. Other eignificant conditions con	ntributing to death but n	ot resulting in the u	inderlying cause	given in Part I.		- 10	ntribute to the cause of death?			
0	requires that the death seen signed by the etter hould be deteched for until the standard by Physicial	Metastatic Disease To liver, Corporny Artery Disease										
rds	v requires been sign should be	The state of the s										
00		Hypercholesterolemi	a, science	Disorder	Azoto	aia	репо	mear	eveilable prior to completion of cause of death?			
R	The lew ate hes by page 2 s						101	es 2000	1 ☐ Yes 2 ☐ No			
ta	certificate rector, pag	25. Was case referred to medical				26. Place of De	ath (Check only o	ne)				
>	Z 0 0											
2	ding Ph After th funerel funerel	27. Manner of Death 1 Senatural 5 Pending	28e Dete of Injury (Month, Day Ye	28b. Time of Injury	V		28d. Describe	escribe how injury occurred				
Sio	Attending or deeth. ector: Affect by the fune	2 Accident investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐ No						
Division of Vital Records,		4 Homicide determined	28e. Placa ot Injury building, etc. (S	- At home, term, st Specify)	reet, factory, offic	20	City or Tow		er or Rural Route Number,			
	Hospi 24 hou Funer Funer stely fill	29a. Certifier (Check only one) Medical Examination	sician: To the best of m ner: On the basis of exi and manner stated	aminetion and/or ir	h occurred at the vestigation, in m	time, date end plec y opinion, deeth occ	e, end due to the curred at the time,	ceuse(s) and ma date and place,	nner es stated. end due to the cause(s)			
	To the comple	29b. Signature and titler of entitier	110		29c. Lice	ense number		29d. Date signe	d (Month, Day, Year)			
	->-0	> /MMM	UN	MD	DI	0517	49	08/	04/2000			
	10	30. Name and address of person who co	impleted cause of deeth	(Item 23a) (Type				,	1 2 2			
	SW	30. Name and address of person who co DR Harsh Bhushan		-	ere Drive	BaHir	nore v	Maryle	no 2125+			
	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	In it							



	NALD CKSON	A	MEND ITEMS: #23 PA	State of Marylan			Mental Hyg		24752			
	Physicia /Medic Examin	n al	1. Decedent's Name (First, Middle, Las RONALD 4e Fecility Neme (If not institution, give	TYRE	E J	ACKSON 4b. City, Town, or	2. Date of Dee Month JULY	th				
	Funeral Director	MARYLAND GENERAL HOSPITAL 5. Social Security Number 6. Sex 1 M 2 F 7. Age (tn yrs. last birthday) Wonths Days Houra Min. 4 G Yrs. Wonths Days Houra Min. Aug 26, 1953 9. Birthplace Country) V 1 F Usual Residence of Decedent										
5-0020	72 hours after deeth with the Maryland natural, or flems 23s or 28s-1 show scal Examiner must be notified at	I Director	10a. Stale 10b. County MARYLAND N 10e. Street and Number	IA 10c. Cit	y, Town or Location	BALTIMO.		10g. Offizen of Who	10d. Inside City Limits 1 Xes 2 □ No at Country?			
	hours after deeth ural', or Hems 2 il Examinat mu	d by Funeral	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 24 Yes 2 ☐ No If Yes, Give Year or Dates:	1 Yes, sp		pecify Yes or No- o Rican, etc.)	Black, Specify:	American Indian, White, etc. BLACK			
121	d within giena. or than	\circ	15. Decedent's Ed (Specify only highest gre- Elementery/Secondary (0-12) UNKAPOWN	ucation de completed) College (1-4or 5+)	life. DO NOT	ork done during most of wo use retired) ABORER		16b. Kind of Busin	ness/industry			
arylan	should be ind Mental marked o	To Be	17. Father's Neme (First, Middle, Last) WILL I AM 19a. Informent's Name/Reletionship (7)	ype. Print)	LOGAN 19b. Meiling Addres	GRA ss (Street end Number or R	CE	Meiden Surneme) r, City or Town, St	JACKSON ete, Zip Code)			
more, M	Pages 1 and 2 ent of Haelth e alt if frem 27 fa ny or other tre		A L BERTA JACK 20a. Method of Disposition 1 Burial 2 Cremelion 3 Characteristics 4 Donation 5 Other (Specify	Removel from State	3911 F. Place of Disposition (Notemetery, cremetory or	other place)	Dete	20c. Location - Ci				
Balti	Departm Departm Imports any inju		21. Signature of Funeral Service Licenses 22. Name and Address of Fecility 22. Name and Address of Fecility 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, interval Between interval Between									
A	Physician /Medical Examiner		shc k, or heart feilure. List only Immediate Ceuse (Final disease or condition resulting in death)		RICARDIUM				Interval Between Onset end Deeth			
	d ansit	Examiner		AORTIC DISSECTION b Due to (or as a consequence of):								
	sicia bur	- Ca	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):								
P.0	d by the	Phy	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	ceuse given in Part I.			ibuta to the cause of doeth?			
ecords	e lew requires the been signing 2 should be	mpleted by	Completed by	*				perto	/	24b. Were autopsy findings evallable prior to completion of cause of death?		
=	iclen: The L certificate he rector, pege		25. Wes case referred to medical			26 Place of De	ath (Check only o	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No				
Division	hys his	ation: To Be	exeminer? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	[ER/Outpatient 3 [Other:	Home 5 🗆 Resid	lence 6 Other				
	Hospital or Attend 24 hours after deeth Funeral Director: , stely filled in by the ;	i Certification:	3 Suicide 6 Could not be determined	building, etc. (Specif	(y)		City or Tow	m, State)	or Rural Route Number,			
	2 E 2 d	Medicai	29a. Certifler (Check only one) 29a. Certifler (Check only one) 29b. Signature and fitte of certifler (Month, Dey, Yes.) 29c. License number 29d. Date signed (Month, Dey, Yes.)									
	4		J. C.	Mouen	7011	O.C.M.E.	2	AUGUST 1,	2000			
	6		30. Name and address of person who	empleted gause of death (Item PCS TOWN PC 32 Aegistrar's Signa	111	Penn Street,	Baltimo	re, Mary	land 21201			
	Stai Registra		AUG 0 7 2000	32,516gistrar's Signie	D. As	all!						



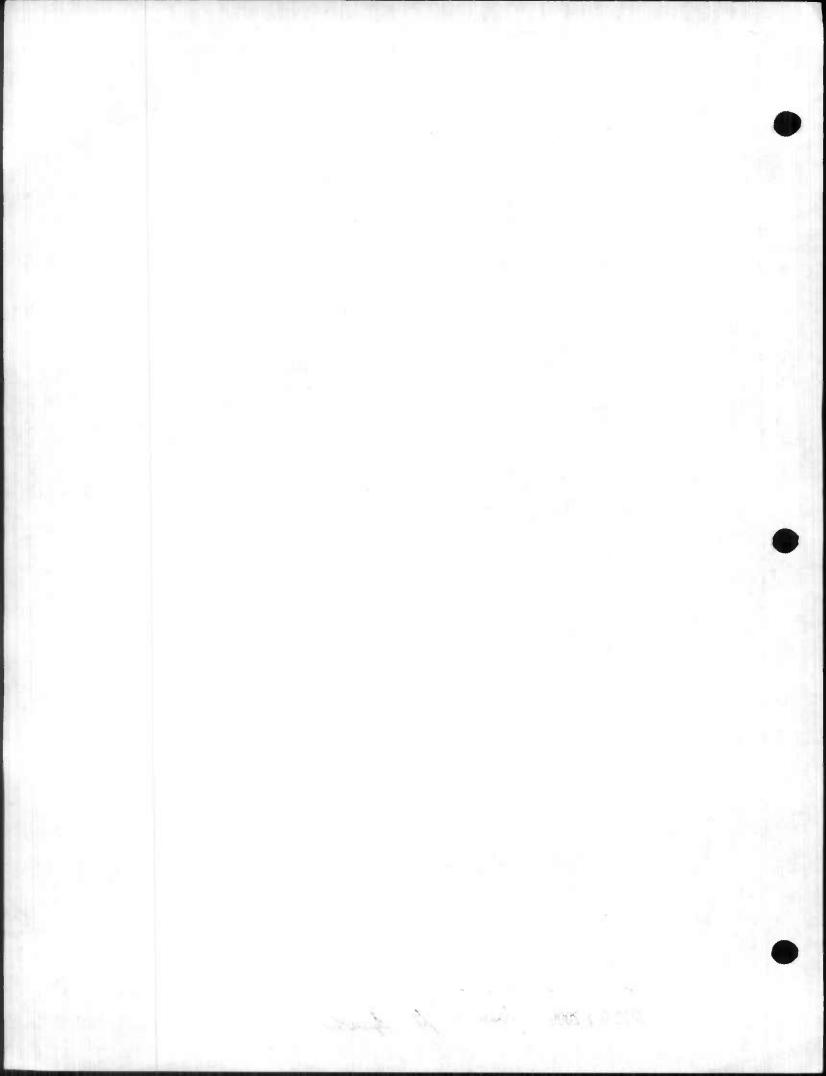
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State of Maryland / Department of Health and Mental Hygiene

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ANDREW JACKSON

					Certif	icate c	of Death			Reg. No.		
		1. Decedent's Neme (First, Middle, Las	st)			-			2. Date of De		Vee	3. Time of Death
	sician	ANDREW JACKSON							Month JULY	17, 200	Year O	1645 PM
9	edical miner	4a Facility Name (If not institution, giv. 501 EAST PREST)	street and number)	APT.#1	123			wn, or Lo	cation of Death			
Fune Direct		5. Social Security Number 6. S UNK 1	ex 7. Age	(In yrs. last bi		Under 1 Ye		24 Hrs. Min.	8. Date of Birt (Month, Da Apr 18	h v, Year) 1926	9. Birthp	place (State or Foreign
		Usual Residence of Decedent		/ 4				1	API 10	1720		UIIK
anytano		10a. State 10b. County	76	10c. City, Tov	wn or Location	ion					1	Od. Inside City Limits
ha Mar 28s-f at	Director	MD N/A				altimo				10- China at	Min at Court	1X Yes 2 □ No
ath with t	rai Dir	10e. Street and Number 501 E. Preston S	treet #12:	3		10f. Zip Cod	21202			10g. Citizen of Whet Country? USA		
V1215-6020 within 72 hours after death with the Manyland ene. than "netural", or heme 23e or 28e-f show then "netural".		11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 Ne If Yes, Give Year or Dates:			Decedent es, specify C			ecify Yes or No Rican, etc.)	Specif	ca - Americ ck, White,	
Pater Pater		15. Decedent's Ed (Specify only highest gra	ucation		Decedent	's Usual Oc	cupation	t of work	ina	16b. Kind of B	usiness/In	dustry
be filed within 72 hours af tall Hygiens. d other than "natural", or devent, presented to the tall tall tall tall tall tall tall tal	Completed	Elementary/Secondary (0-12) unk	College (1-4or 54	+)	unk		one during mos tired)	of Or WORK	ing .	un	k	
	Ö	17. Father's Name (First, Middle, Last)	GIII		GIIIC		18. Moth	er's Name	e (First, Middle,			
Maryland 212 d2 should be filed within th and Mental Hygiena. 7 is merked other than traumatic avant, pre M	To Be	unk					unk					
Maryla 12 should h and Men 7 is marke traumatic	14.11	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing A	ddress (Str	eet and Numb	er or Run	al Route Numbe	er, City or Town	, State, Zip	Code)
		O.C.M.E.		1	11 Per	nn St	reet E	Balti	more, M	D 2120	1	
Dallimore, N permit. Pages 1 and Department of Health Important: If tem 27 any Injury or other to		20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 ☒ Other (Specify	Removal from State	20b. Place comete	of Dispositio ery, cremato				Date	20c. Location	- City or To	own, State
permit. Pages Department of H Important: If the	DUCE.	21 Signature of Funeral Service Lice Ronald S.	Wada Dire	ector	St	ate A		Boar		W. Bal	timor	e Street
-		23a. Pert1. Enter the disease, or compshock, or heart failure. List only	olications that caused t	the deeth. Do	not enter th	he mode of	re, MD dying, such as	cardiac	or respiratory a	rest,		Approximate Interval Between
/Medic Examin	er	Immediate Cause (Final disease or condition resulting in deeth)	b	Oue to (or as a	consequen	nce of):	sculor	Dis	ease			
asth certificate be executed attending physician and for use as the bunial-fransit	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (or es e								
	Cia	Port II. Other standilanet conditions of	atabution to doub but	ant convities	in the codes	-hilan sauce	nium in Dani		22h Did	lohanno una no	antellación f	o the sauce of death?
the the	Physician/	Part II. Other significant conditions of	ontributing to death but	in the under	nying cause	given in Per	1.	23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 45				
aw requires to be sign 2 should be	pieted								TNS	en autopsy med? PECTION	ev of	ere autopsy findings eilable prior to ompletion of cause death?
- F # 6									10	- ' '	11	☐ Yes 2☐ No
vital sicien: T cartificate irector, pe	Be	25. Was case referred to medical examiner?	Hospitel:			_	Other:		h (Check only o			
Phy Physical	lon: To	1 Xyes 2 No 27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 □ ER/O (Year) 28b.	Time of Injury	28c. I	njury at Work?		ome 5 Residence			M AT SCENE
Attant ar daat ector: by tha	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, f (Specify)			1 □ Yes 2 □ ica	NO	28f. Location (. City or To	Street and Num vn, State)	ber or Run	al Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir complataly filled in	edical		vatcian: To the best of liner: On the basis of and manner stat	examination a								
To the within 2 to the comple	×										ed (Month,	Day, Year)
F 3 F 5		h. D. O.C.M.E								JULY	18,	2000
		30. Name and address of person who	completed cause of de	111	(Type, Prin	Stre	et, Bal	Ltimo	ore, Mai	yland 2	21201	
	State	31. Dete filed (Month, Day, Year)	32 Angistra	_	4	1.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24754 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** UAMES ALBERT 100 1452 AUGUST /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Topb Balta If Under 24 Hrs. m em mon If Under 1 Year 5. Social Security Number 6. Sex 120 M 2□ F 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdev) **Funeral** 42 233 Hours 5 212 5 d Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b County 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or frems 23s or 28s-4 show any fujury or other traumatic event, ma Wadical Examinal must be notified an ence. al Yes 2 No N.A Funeral Director 9 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 824 U.S. A 1)rivE 212 ARGONNE 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indian 11. Meritel Status Black, White, etc. 1 Never Married 2 Married Black Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) IrealmeN. 121 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Will itucherson maria 19b. Mailing Address (Street end Number or Rurel Route Number, City or Jown, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Basto md 21205 Jda B. SCHIVEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9 00 LION @ M 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1304 Lacks ocko 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or haert failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Seosis hours Entiment Due to (or as a consequence of): Physician/Medical Examiner Dua to (or es a consequence dy). hours the attending physician and hed for use as the burial-transit The law requires that the death certificete be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Box 68760. 14 hours Hepatic Encephalopathu Dua to (or es e consequence ol): Hepatic signed by the a P.O. 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Inknown 1 Yss 2 No Division of Vital Records, ð Also Attenues are after this certificate has been a serious of the funeral director, page 2 should be the funeral director, page 2 should be the funeral director, page 2 should be the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Medical Certification: To Be Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 2000 AT 243894 Water 30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print) Baltimore Westson E. University MD 21218 Deborah W.D. UMH

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year).

AUG 0 7 2000

32. Registrar's Signature

443 8 2500 June H. Marie

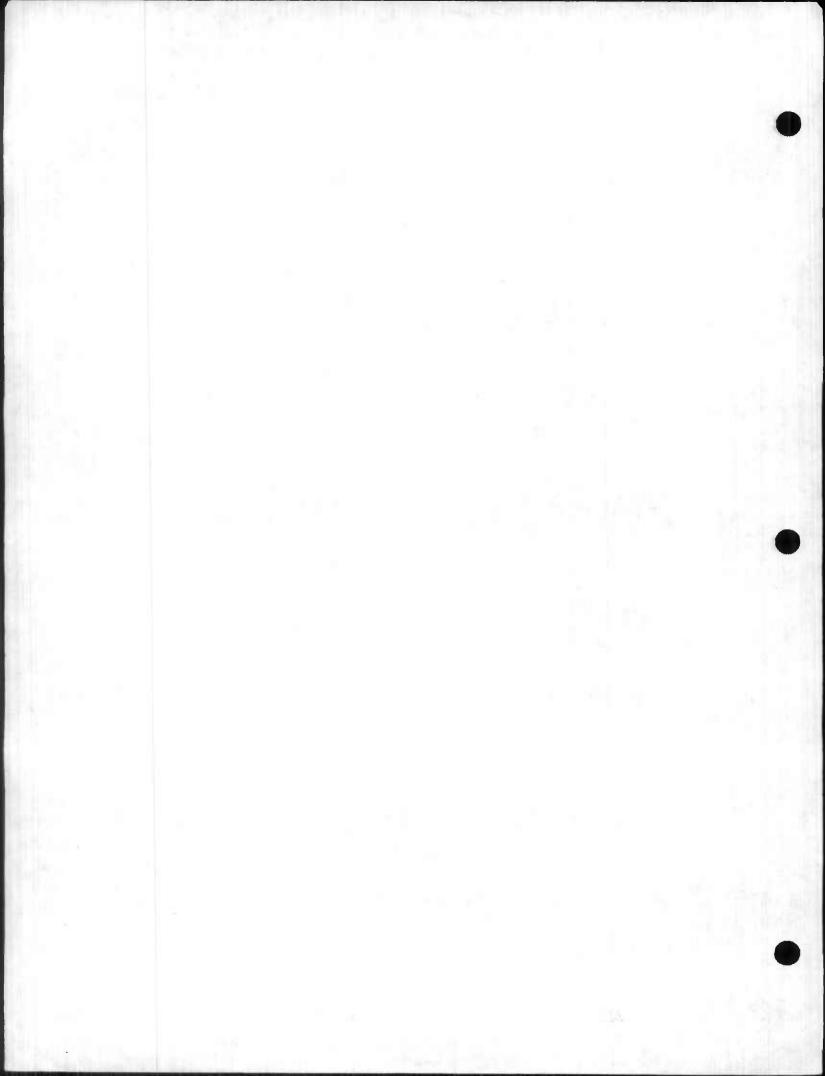
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Quinten Johnson		State of Maryland	I / Department of Health and	Mental Hygiene ()	24755
AMEND ITEMS:	#23 PART	I, 27 PER MEO	/ Department of Health and	Reg. No.	

	TEMS: #23 PART I 1. Decedent's Name (First, Middle, Las.				2. Dete of Deeth	g. No. 🕖	3. Time of Death
Physician	Ouentin	C.	Johnso	on Jr.	July 30	Day Yes	6:22 am
/Medical Examiner	4e Facility Neme (If not Institution, give			4b. City, Town, or		4c. County of D	
LABITITICS	St. Agnes Hospita	1		Baltimo	re	N/A	
Funeral	5. Sociel Security Number 6. Se		st birthday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth		Birthplece (State or Foreig Country)
Director	217-57-1488	DM 2□F	Yrs. Months Deys	Hours Min.	(Month, Dey, 1	2000	M · D ·
B	Usuel Residenca of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limit
aho a							1 🕅 Yes 2 🗆 N
with the Mar tor 28a-f s be notified Director	MD NA 10e. Street and Number	Ba.	Ltimore 10f. Zip Code		10	. Citizen of Whet	Country?
DI DI			Tot. Zip Code		10	J. Citizen of Whet	Country
a 23	716 Bethnal Ro	ad 12. Wes Decedent Ever in U.S		1229	to a sife. Van as No	U.S.	A . merican Indien,
r heme 23	11. Meritel Stetus	Armed Forces?	 13. Wes Decedent of If Yes, specify Cult 	oan, Mexican, Puer	o Rican, etc.)		hite, etc.
al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Detes:	1 ☐ Yes 🌠 No	Specify:		Specity: B	lack
2 should be lined within 12 hours after death with the maryand and Mental Hyglene. Is marked other than "natural", or itema 23a or 28a-f show surratic event, the Medical Examine mass be notified at To Be Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad	ucation fe completed)	16a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	pation during most of wo	rking	6b. Kind of Busine	ss/Industry
ges 1 and 2 should be filed within t of Heath and Mental Hygiene. If itsm 27 is merked other than or other traumatic event, the M To Be Comp	Elementery/Secondary (0-12)	College (1-4or 5+)		, ,			
Hygiene. Wher ther and, the		N/A	N/A	19 Mother's No	ne (First, Middle, Me	N/A	
Be very						siden Sumeme)	
ind Mental in marked o umatic eva					Harvey		
and la ma	19e. Informent's Neme/Relationship (T	ype, Print)	19b. Meiling Address (Street	t end Number or A	ural Route Number,	City or Town, Stet	e, Zip Code)
Health am 27 other tr	Lisa Harvey-Gua	rdian	716 Bethnal	Road,			21229
T than	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I	20b. Ple	eca of Disposition (Name of metery, cremetory or other plants	ece)	Dete 2	Dc. Location - City	or Town, Siele
in it is a	4 Donetion 5 Other (Specify,		outus Mem. I	Park 8/	5/00	Arbutus	, Md
Department of Health Important: If Item 27 any Injury or other to 20058.	21 Signature of Funeral Service Licens		22. Name and Addr March F				
Depa Impo any I	Ml Day of	Think)			Dalei	hM aran	21215
	23a. Part I. Enter the tisease, or comp	lications that caused the death.	2300 Wak				Approximate
husisian	shook or heart lallure. List only o	ne ceuse on eech line.					Onset end Deeth
hysician /Medical	Immediate Cause (Final	ACITUE	BRONCHOPNE	ATMONTA			
xaminer	disease or condition resulting in death)	a	J. Ditorionol III				
j .		Due to (or	es e consequence of):				
ial-transit		b					
al-tra	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or	es e consequence of):				
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physicials the burner of the b	thet initieted events resulting in death) Lest	Due to (or a	as a consequence of):				
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d by the attending etached for use e							
y the a ached f	Pert II. Other eignificant conditions co	ntributing to death but not resul	ting in the underlying cause g	iven in Pert I.	23b. Did tob	acco use contrib	ute to the cause of dear
ed by the detached					1 □ Ye	2 2 No 3 □	Probably 4 Unkn
90							
page 2 should be Completed by					24a. Wes en perform		 Were eutopsy finding eveileble prior to
2 sh							completion of cause of deeth?
page 2					1 DY2	2 □ No	yes 2□ No
certificate h rector, page				26. Plece of De	eth (Check only one)	1 2 3 4
nts certifica if director,		Hospitel: 1 ☐ Inpatient 2 € E	R/Outpatient 3 DOA	ther:	Home 5 □ Resider		Specify)
r this certific and director,		28e. Date of Injury	28b. Time of 28c. Inju		28d. Describe hov		,,,,,
After funer	1 Neturel 5 Pending investigation	(Month, Dey Year)		ork?]Yes 2□No	1000		
al Director: After the In by the funeral Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury - At hor	me, ferm, street, fectory, office		28f. Location (Stre	et end Number o	r Rurel Route Number,
Direction of the property of t	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,	Stete)	
C C						(-)	
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	eician: To the best of my know ner: On the basis of examinetic end menner steled.					
within 24 hours To the Funeral completely filled Medical Co	29b. Signature arist title of certifier	One memor steleo.	29c. Licer	ise number	29	d. Date signed (M	lonth, Day, Year)
	N N	101		M.E.		July 31	
3 - 8	1111	(listo ho	0.0	.11.15.		July 31	, 2000
3 - 8	Cenny	10-000					
3 - 8	30. Name and address of person who o	ompleted cause of deeth (Item)					
× × ×	1	1	11 Penn Stree	t, Baltim	ore, Mary	land 212	01

DHMH 16 Rev 6/95

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Andre Johnson

State of Maryland / Department of Health and Mental Hygiene O NED AMEND ITEMS: #23 PART I, OO, 27 PER Continuate of Death

5. Social Security Number 219-62-6761 6.	John ve street end numb Hopkins	er)			4h City Town	2. Date of 0 Month Augu , or Location of Dec	st 02	Yeer 2000	3. Time of Deeth 01:28 I	
Johns 5. Social Security Number 219-62-6761 6.	Hopkins				4h City Town	or Location of Dea	- Al-			
5. Social Security Number 219-62-6761 6.	-	7 T L -			40. Oity, 101111	, 0, 200211017 01 201	4c. County	of Deeth		
219-62-6761		Hospita	1	30.00		timore		N/A		
		Age (In yrs. les		If Under 1 Yea Months Deys		Hrs. 8. Date of E	lirth Dey, Year)	9. Birthpl	lace (Stete or Forei	
March 1 Dec 1 America of December 1	1 M 2 □ F	43	Yrs.			06-2			ID	
Usual Residence of Decedent		1.0 00 0								
10a. Stete 10b. County			Town or Loc					10	Od. Inside City Lim	
MD NA		Balt	imor	е					XXYes 2	
10e. Street and Number				10f. Zip Code			10g. Citizen of V	Whet Coun	try?	
1053 Hillen St	reet	611-1		212	02		USA			
11. Meritel Status	? (Specify Yes or h		e - America							
1 Never Merried 2 Merried	1 ☐ Yes 2					derito riscari, etc.)	Secritur		ж.	
3 Widowed 4 Divorced	Year or Dete	es:		X X	Specify.		Specify: Bla			
15. Decedent's E	ducation		18e. Deced	ent's Usual Occu	petion	f working	16b. Kind of Bu	usiness/Ind	lustry	
		or 5+)	tife. D	O NOT use retir	ed)	WORKING				
llth Grade	NA		Labo	rer			vario	us t	rades	
17. Fether's Neme (First, Middle, Las	t)				18. Mother's	Neme (First, Midd	le, Maiden Sumem	ne)		
Otis Johnson, Jr. Eunice Bland										
19a. Informent's Neme/Reletionship	(Type, Print)		19b. Meilin	g Address (Street	et end Number o	or Rural Route Num	ber, City or Town,	Stete, Zip	Code) 212	
20e. Method of Disposition										
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		M.C.	-							
21. Signature of Funerer Service Lice	77							_		
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29b. Signature end title of certifier				29c. Lice	nse number		29d. Date signe	d (Month,	Dey, Year)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #9 PER FH G786 8/9/00 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** August 3:50 Am 2000 Young Kya · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Bur VortH Anundel Arundel Hospita if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Days Yrs. Director 228-35-9960 KOREA Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or liems 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Severn Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7813 Halehaven Court 21144 U.S.A Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - Amarican indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Never Married 2 Married ASIAN 3altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Korean Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Engineering 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Be 2 should be fand Mantal I Il Tae Kim Soon Duk Lee 2 19e. informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: If Nem 27 is n eny Injury or other traun Dae Sub Kim / Son 7813 Halehaven Court Severn, MD 21144 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 08-08 T⊟Burial 2 □Cremation 3 □Removal from State Marriotsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2000 Crestlawn 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signatura of Funeral Service Licanses 1 Second Ave. S.W. Glen Burnie, MD 21061 23a. Pact Errier the disease, or an incitations that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical PNEUMONIA

Due to (or as a consequence of): Examiner CEREBROVASCULAR ACCIDENT Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last ettending physician and for use es tha buriel-tren Box 68760 Physician/Medical Due to (or as a consaquence of) 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No à Records, 24b. Were eutopsy findings available prior to 24e. Was an autopsy performed? Completed completion of causa of death? certificata hes 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: To Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident or Attend eftar death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homleide To the Hospital c within 24 hours el To the Funeral D edical 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end menner es stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and placa, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

AUGUST 6 2 29c. Licensa number 29b. Signature and title of cartifier To completed cause of death (item 23a) Type, Sign) TTALD F 30 Name and eddress of person who com

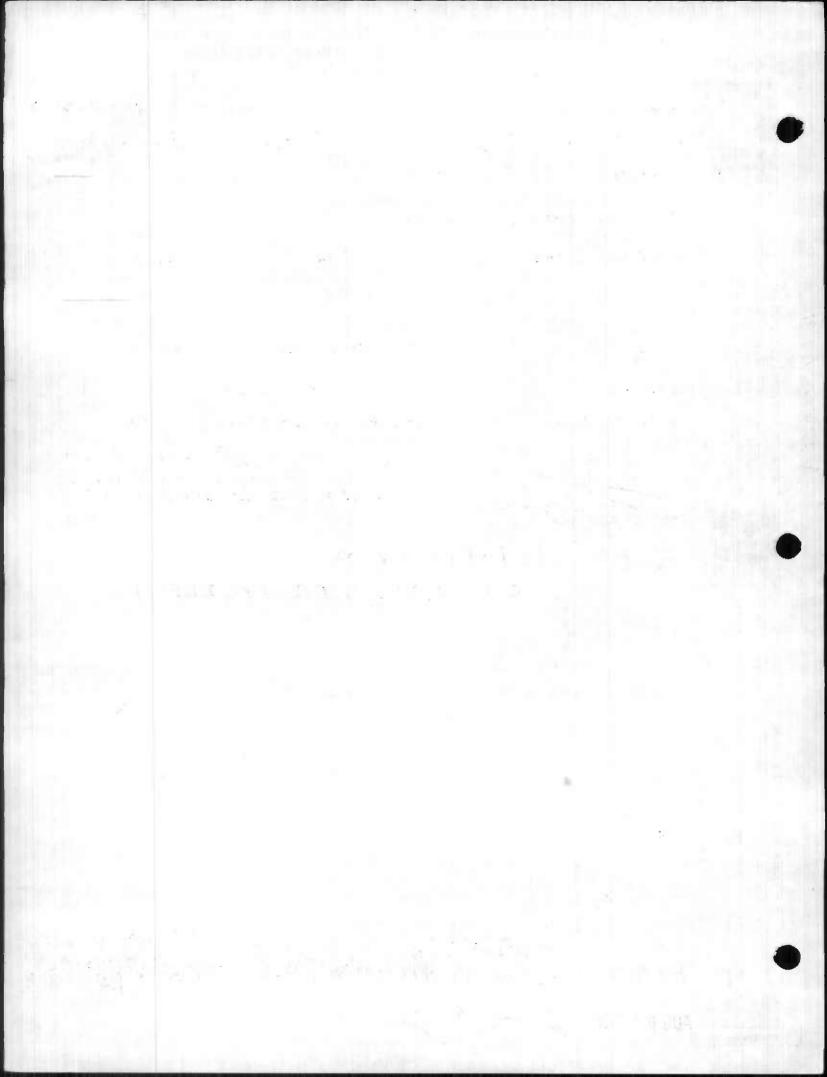
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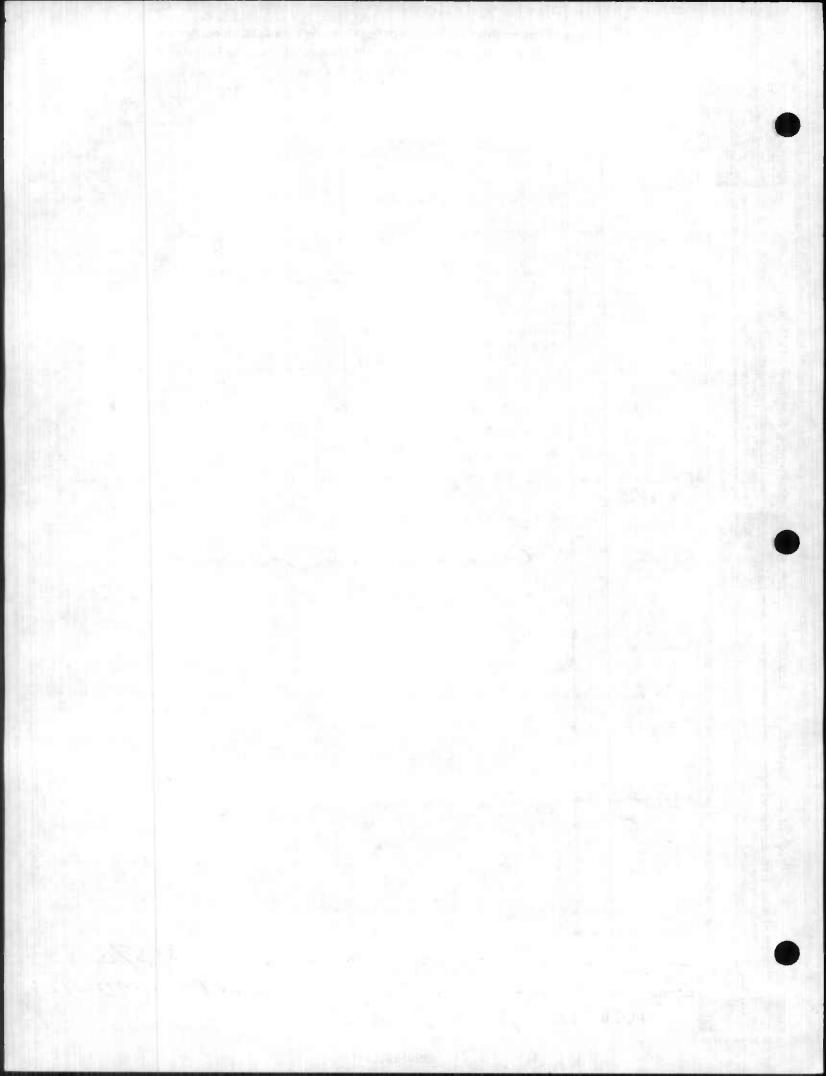


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State of Maryland / Department of Health and Mental Hygiene

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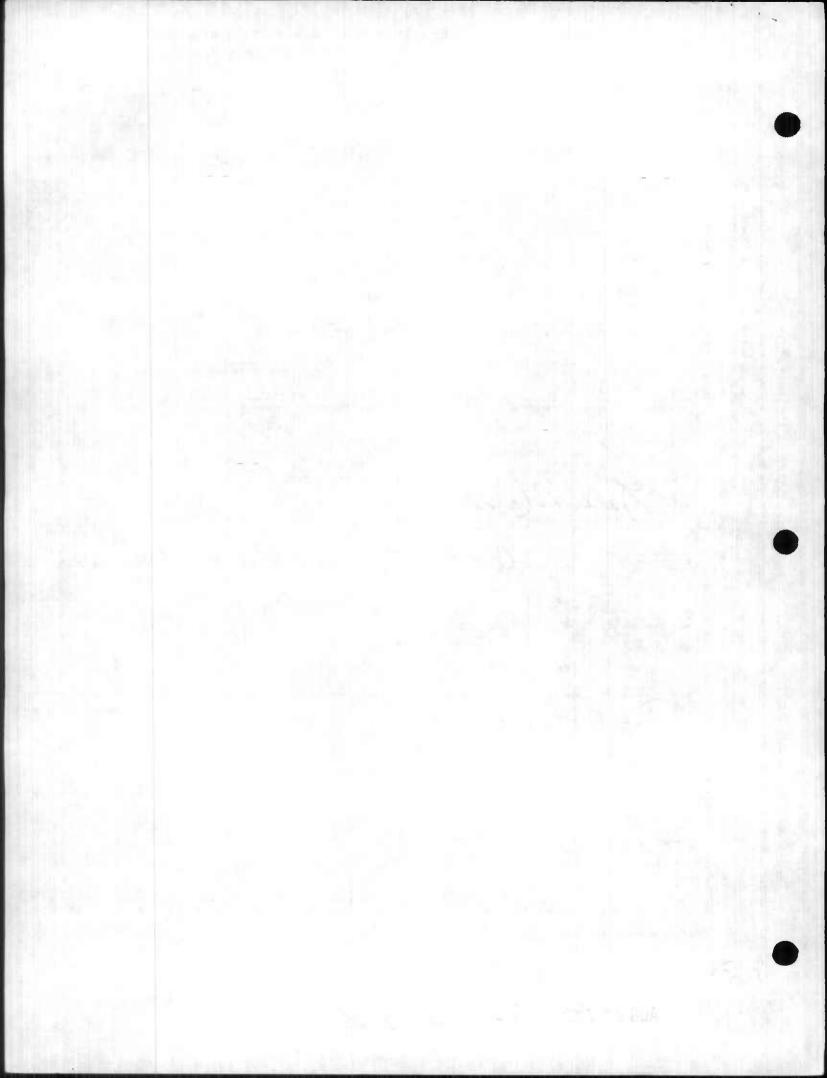
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	Physician		June 1	Elizabeth	Lockhai	rt			Month	30 2	000	7:10 p.m.
	/Medical Examiner	4a Facility Name (If not institution	on, give street end number	r)		-	tb. City, To	wn, or Lo	ocation of Death	-	y of Death	
	Examiner	Bon Secour Hos					Balti	imore	2	N/		
-	- Francis	5. Social Security Number		Age (In yrs. lest birthd	ay) If Under		If Under	24 Hrs.				place (Stete or Foreign
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	or 28a-1 a be notified	10e. Street and Number			10f. Zip	Code				10g. Citizen of	What Cour	ntry?
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State of Maryland / Department of Health and Mental Hygiene 0 0 24760

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	1. Decedent's Neme (First, Middle, Last) MARY LAUMANE	2. Date of Month JUL	Day Year							
Examiner	4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of D								
27/8	5. Social Security Number 6. Sex 7. Age (In yrs.	(SALTIMO) last birthday) If Under 1 Yeer If Under 24 Hrs. 8, Date of								
Funeral Director	1DM 2DE	Months Days Hours Min. (Month	Birth Dey, Year) ar 6, 1910 9. Birthplace (State or Foreign Country) Maryland							
the Maryland 28a-1 show neutrad at	10a. State 10b. County 10c. Cit	y, Town or Location	10d. Inside City Limits 1 ☐ Yes 2☆ No							
the N	Maryland Howard 10e. Street and Number	Ellicott City	10g. Citizen of What Country?							
uth with the Maryle 23e or 28e4 sho unt be noutred at	4002 College Ave.	21043	U.S.A.							
r dea	11. Menital Status 1 Never Merried 2 Merried 3 Midowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☑ No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White							
12 mg and de	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	16b. Kind of Business/Industry Home							
nd 2 e filed other, went, Be Co	5th 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	dde, Maiden Sumeme)							
ylan ylan Mentel Mentel mrked o	Charles Scott		Edith Tucker							
re, Maryland 21 s 1 and 2 should be filed wi f Health end Mentel Hygien fem 27 ie marked other un other treumatic event, tre To Be Com	19a. Informant's Neme/Relationship (Type, Print) Ms. Ava Farmer	19b. Mailing Address (Street end Number or Rural Route No 4004 College Ave. Ellicott City, Mai								
Baltimore, Maryland permit. Pages 1 and 2 should be fit Department of Health and Mantel th Important: if them 27 is marked oth any Injury or other traumatic even and. To Be	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Placa of Disposition (Neme of emetery, cremetory or other place) Good Shepherd Cemetery 07/15/0	20c. Location - City or Town, State Ellicott City, Maryland							
Balti permit. Departm Importa any Inju	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Elli	cott City, MD 21043							
Physician	23a. Part1. Enter the disease of complications that caused the death nock, or heart failure. Est only one cause on each line.	The state of the s								
/Medical Examiner	1050kiig ii 00atii)	0579515	DAYS							
iner and		or as a consequence of): ARY TRACT IN FECT	24 to hor							
68760, ficate be executed physician and s the burial-transit edical Examiner	if any, leading to immediate	r as e consequenca of): ERAL PMEUMOMIA r es e consequenca of):	DA 75							
Box 68760, eath certificate be ettending physician for use as the burist clan/Medical E	thet initiated events resulting in death) Last Due to (o		YEARS							
O. Box (the death certify the ettending sched for use a hysiclan/Mi	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I. 23b.	Did tobacco use contributs to the cause of death?							
IS, P.O. Box as that the death certigoed by the ettending be detached for use a by Physician/M	COROMARY ARTERY	1 Yes 2 No 3 Probably 4 Unknown								
Cord Spen s Should	CONGESTIVE HEART		Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?							
al Rec i: The lew icate has it, page 2:	CHROMIC ANE MIA		☐ Yes 2 No 1 ☐ Yes 2 ☐ No							
/ital	25. Was case referred to medicat	26. Place of Death (Check o	nly one)							
To I dire	1 Yes 25 No Hospital: 1 Anpatient 2 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Dey Year)		Residence 6 Other (Specify) ibe how injury occurred							
Division of the Hospital or Attending Pin 24 hours after death. The Funeral Director: After the plately filled in by the funeral edical Certification:	2 Suiside 6 Could not be	ome, farm, street, factory, office 281. Locati	on (Street and Number or Rurel Route Number, Town, Stete)							
Ne Hospitu ne Zu hours Ne Funera plately fille	29a. Certifier (Check only one) Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examinal and menner stated.	wledge, death occurred at the time, date and place, and due to tion and/or investigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)							
To th withir comp	29b. Signature and title of cartifier	29c. License number P 1 3 5 9 5	29d. Date signed (Month, Day, Year)							
	> Bonnie mo	JULY 11 2000								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE BAFFOE-BONNEE ST. AGNER HOSPITAL. BALTIMORE MO.									
State Registrar	AUG 0 7 2000 Sener 32. Registrar's Signa									

00-4320-510 Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. ihm State of Maryland & Department of Health and Mental Hygiene . 0 APRIL LAUDERDALE AMEND ITEMS: #23 PART I, Certificate of Death 27 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day **Physician** Lauderdale April 4b. City, Town, or Location of Death 02 2000 4c. County of Deeth /Medical 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE SINAI HOSPITAL 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months Days Hours 1 M 2 K F Yrs. 38 Director 214-70-9778 M.D Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 28a-f show man be nothled at Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 U.S.A. Herns 23a 21217 2326 Bryant Ave death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if fram 27 Is marked other than "natural," or frem any Injury or other traumetic event, tre Medical and Andrews. Black, White, etc. W Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Bennett Ernest Lauderdale 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stele, Zip Code) Lois Canty-Daughter 2326 Bryant Ave, Baltimore Md

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date

20c. Location 20c. Location - City or Town, State 20e. Method of Disposition MQBuriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 8/5/00 Randallstown, Md

Physician /Medical Examiner

Box 68760

P.0.

Records,

Division of Vital

To the Hospital or Attending after death

within 24 hours To the Funeral I completely

21. Signature of Fynerel Service Licensee

1,221

Completed by Physician/Medical Examiner ician and bunal-transit edicai Certification: To Be filled in by

2

this

23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dee one cause on each line.			e, Baltimore N	Approximate Interval Between Onset and Death
Immediate Cause (Fine) disease or condition		DIAC ARRE	AIMHTY		
resulting in death)				PATHY ASSOCIA TENSIVE CARDI	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	or as e consequenca of)	TOTAL PROPERTY.	4-187	
that initiated events resulting in death) Last	Due to (d	or as e consequence of)			
Pert II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did tobacco use co	ntributs to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				¥SYes 2□No	yRyes 2□ No
25. Was case referred to medicat			26. Place of De	eeth (Check only one)	
examiner? 1 Yes 2 No	Hospitet: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3 D	OA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Oth	ner (Specify)
27. Manner of Deeth 1 2 Natural 5 Pending 2 Accident investigation		28b. Time of tnjury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined	28e. Ptece of Injury - At h building, etc. (Speci	ome, farm, street, factor	y, office	28f. Location (Street end Numb City or Town, Stete)	ber or Rural Route Number,
29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	/sician: To the best of my knowiner: On the basis of examination and manner stated.	owledge, deeth occurred ation and/or investigetion	et the time, date and place i, in my opinion, death occ	e, and due to the cause(s) end mo urred at the time, date and place,	enner es stated. and due to the cause(s)
29b. Signeture end title of certifier		29	c. License number	29d. Date signe	d (Month, Dev. Year)

OCME

111 Penn Street, Baltimore, Maryland 21201

22. Name and Address of Facility
March F/H West

AUGUST 03, 2000

3. Time of Death

10d. Inside City Limits

No 2 □ No

00:56 AM

State Registrar

31. Date filed (Month, Dey,

Neme end address of person who completed cause of death (Item 23a) (Type, Print)

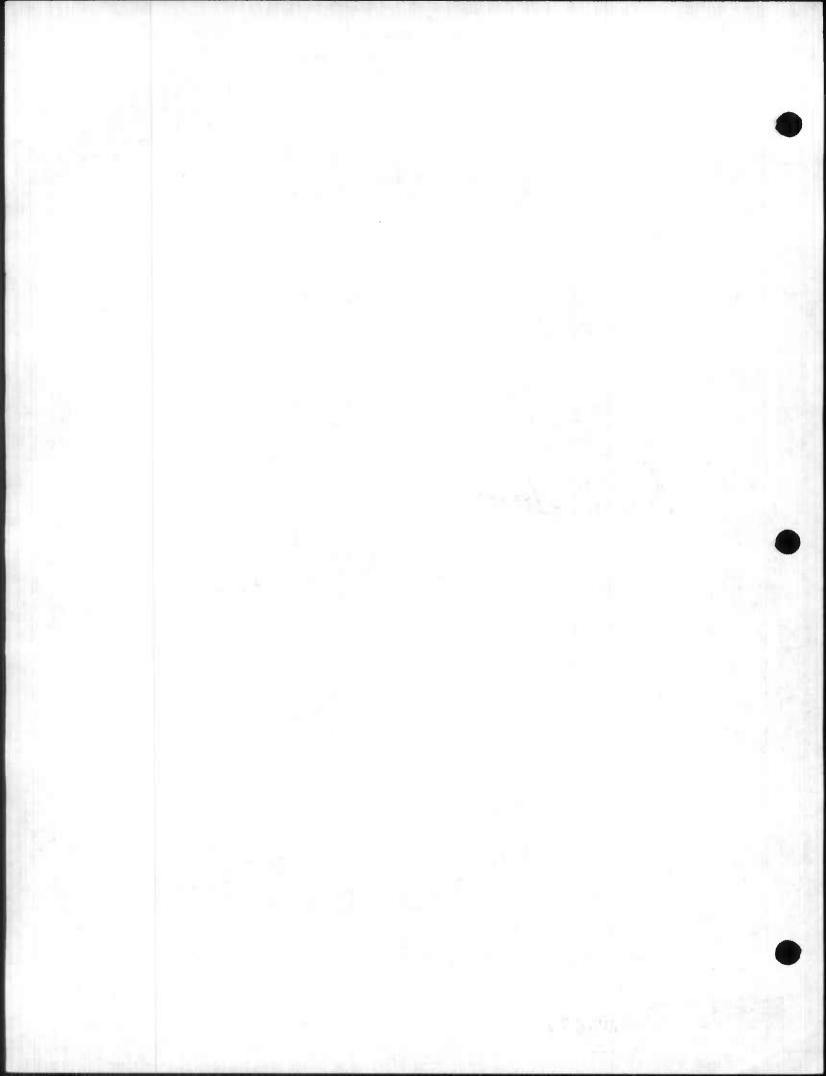
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	1 Decedents to	lama /First & Biddle 1 -	et)				2. Date of Dea	Reg. No.	1	3. Tima of Death
sician	1. Decedent's Name (First, Middle, Last)						Month	Day	Year	2:47 P.N
eal ner	4h City To						July 31 2000 2:47 1, or Location of Death 4c. County of Death			
er							ore	N	/A	
	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthdey) If Undar 1 Yaar					If Under 24 Hrs.	8. Date of Birtl (Month, De)		*	ca (State or Forai
		8-0259	109M 20 F 5	2 Yrs.	Working Bays		11-18			ĺĎ
	Usual Residence	10b. County		10c. City, Town or	Location				100	d. Inside City Limi
ō	MD									1 Yes 2 N
Director	10e. Street and Number 10f. Zip Code						10g. Citizan of What Country?			y?
	411 Ed	sdale Roa	ad Apt. "	'C"	2122	29		USA		
by runeral	3 🗆 Widowe	us Aarriad 2 X Married ed 4 Divorced	Armed Forces?	2. Was Decedent Ever in U,S. Armed Forces? XI XI Yas 2 □ No If Yes, Giva 1 □ Yes 2 ☑ N			pecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black	
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0	Henry	s Name/Relationship (Lyons Type, Print)	19b. Ma	iling Address (Stree		ral Route Numbe			-
	Franc				N. Milt					
	20a. Mathod of	Disposition		20b. Place of Dis	position (Neme of rematory or other ple	ace)	Dale	20c. Location - C	ity or Tow	m, Stata MD
		2 ☐ Cremation 3 ☐ on 5 ☐ Other (Specify			on Fores	_	m. 08-	07-2000	Owi	
	Immediata Cau disease or cond rasulting in dea	dition	. Volu	1-15018	A. 11 C					1 - 1 - 1
an/Medical Examiner	Sequentially listif any, leading to cause. Enter U Cause (Disease that initiated everesulting in dea	t conditions, to immediate Indarlying e or injury ents	C	Due to (or as a cons		plica	tion:	Z I	7	ares
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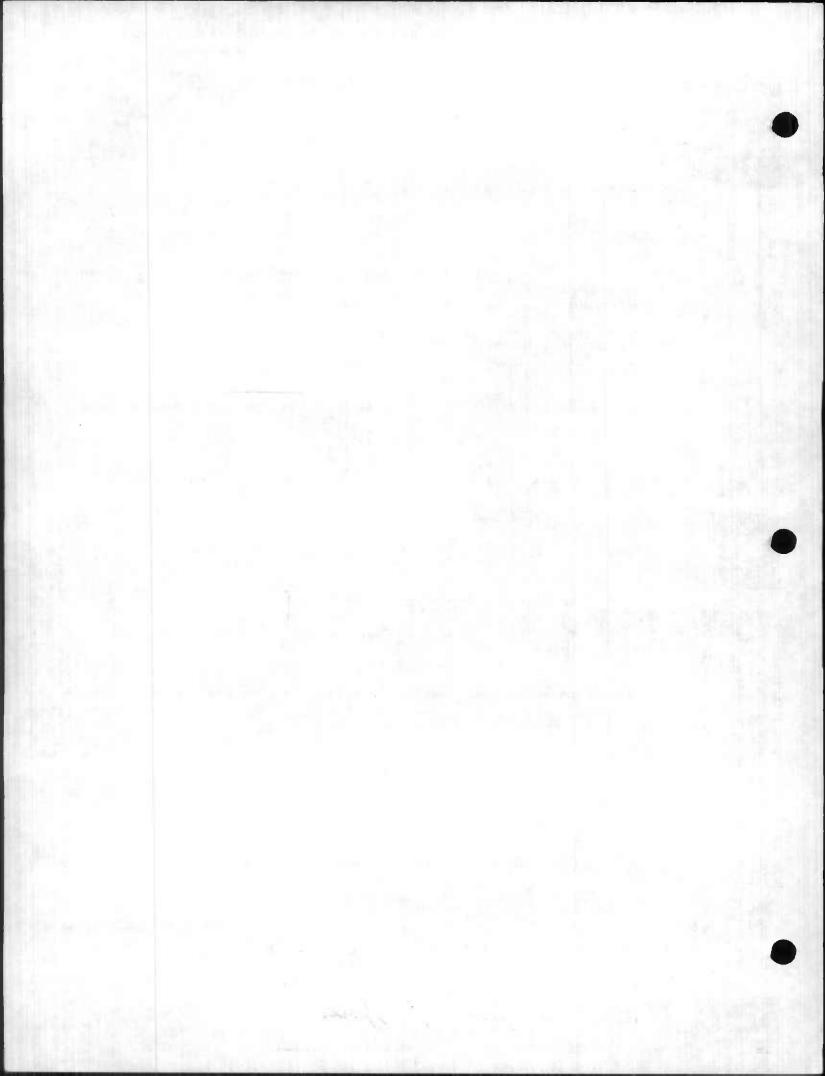
DHMH 16 Rev 6/95

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Amende Amend	ed it	em # 4a per tem#18 perFF	ME G786 8- IG786 8/17/2	State of 17-00 Wjj 2000 EW	Marylan	d / Depa	artment of tificate of	Health a Death	and M	ental Hy	/giene () (Reg. No.) 2	24764		
Phys /Me Exar	dical	Ruth K. Levitt 4a Facility Name (If not institution, give street end number)							own, or Lo	2. Date of Do Month August cation of Deal	Day 4,	Day Year			
Funer Directe		2673 7 Cu 5. Social Security 0 014-14-2		Hole Roa Sex 7 1□ M 2MF	d Age (In yrs. 80	last birthday) Yrs.	If Under 1 Yaar Months Days	If Undar	polis 24 Hrs. Min.		Anne sth. Year) 29,1920		ndel place (State or Foreign ntry) ssachusetts		
	Meryland a-f ahow Mad at	Usual Residence of 10a. Stata	of Decedent 10b. County	undal		y, Town or Lo							10d. Inside City Limits		
death with the Meryland ms 23s or 28s-f show	Funeral Director	Ma. Anne Arundel 10e. Street and Number 2673 Cunningham Hole Road				Annapolis 101. Zip Code 21401				10g. Citizen of Wha			at Country?		
15-0020 72 hours after "natural", or the	by	11. Marital Status 1 ☐ Nevar Mar 3 ☐ Widowad	Armed Force 1 Yas 2 If Yes, Give			Vas Decedant of Yas, specify Cul	igin? (Spe n, Puarto i	cify Yas or No Rican, etc.)	o- 14. Rac Blac Specify						
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Baltimore, permit. Peges 1 en Department of Heel Important: if item 2: any injury or other	poce.	4 ☐ Donetion 21. Signature of F	5 Other (Specification Service Lice	fy) nsee	Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society										
Physicia /Medic Examine	al er		the disease, or com art failure. List <i>only</i> (Finel on	plications that cau	Ovo	h. Do not ente	ingeal	ing, such as	cardiac o	r raspiratory e		2122	Approximate Interval Between Onset and Death		
Box 68760, eeth certificete be executed ettending physician end for use as the burial-transit	Medical Examiner	Sequentially list of if eny, leading to icause. Enter Und Cause (Disease of their initiated even resulting in death)	mmediate lerlying r injury ts	b	Due to (or as a consequenca of): Due to (or as e consequenca of):										
P.O. het the dd by the detached	by Physician/Me	Pert II. Other signi	ificant conditions	contributing to dea	ontributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown					
ew requires been 2 should	Completed b									24a. We perf	s an eutopsy formed?	an Co	Vere autopsy findings vaileble prior to ompletion of causa I death?		
of Vital Representations of vital Relations of the level	8	25. Was case refe examiner?	rred to medical	Hospital:		ED/O 4		ther:		(Check only			☐ Yes 2☐ No		
After fune	Certification: To	27. Manner of Dea 1 Naturel 2 Accident 3 Suicide 4 Homicide	<u></u>	28a. Date of (Month)	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work? M 1 Yes 2 No					Home 5 Rasidenca 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)					
Division To the Hospital or Attent within 24 hours efter deat To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier (Check only one) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the and menner stated.													
To the comp	Me	29b. Signatura	d) the of certifier	ouil	zu	0	29c. Licer	983	38		29d. Date signe	200	Day, Year) 0 1, 2140(
, v	8	Stuart	ress of person who	louich,	of death (Item O. O gistrar's Signa	900	Bect	gate	Rd.	Anv	iapolis (Mi	1. 21401		
Regi	State strar	31. Date filed (Mo	JG 0 7 200	00	The Solution	B	Spork	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MOSES AUG OTHELIA 1:15 A.M. 04 2000 4a. Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death NURSING Home ... BALTIMORE If Under 24 Hrs. 8. Date of Birth LORIEN 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign , Country) 1□ M 2XF 213-62-8403 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARULAND 10e. Street and Number 10g. Citizen of What Country? RANK FORD AVENUE 500 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS REPRESENTATIVE VRS 17. Fether's Name (First, Middle, Last) AVMOND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5431 OMAHA AVE., BALTIHORE, M.D. 21206 lace of Disposition (Name of Date 20c. Location). City or Town, State (BROTHER) JAMAL MOSES 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State VOSHELL CEMETERY 8-800 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Fecility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIHORE, Mp. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate of Funeral Servica Immediate Cause (Final Bacterial Endocarditis disease or condition resulting in death) Due to (or as e consequence of): Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No

Physiclan /Medical Examiner

and

physician as the bunal

signed by I

Physician/Medicai

þ

Completed

Be

P

Medical Certification:

P.O. Box 68760,

Records,

Division of Vital

To the Hospital or Attending Physicien: Within 24 hours after death.

After

Director: /

Within 24 hours aff To the Funeral Di completely filled in

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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Director

Funeral

by

Completed

Be

P

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer death w Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23a any injury or other traumatic avant

Baltimore, Maryland 21215-0020

the Maryland

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Manner of Death 28a. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

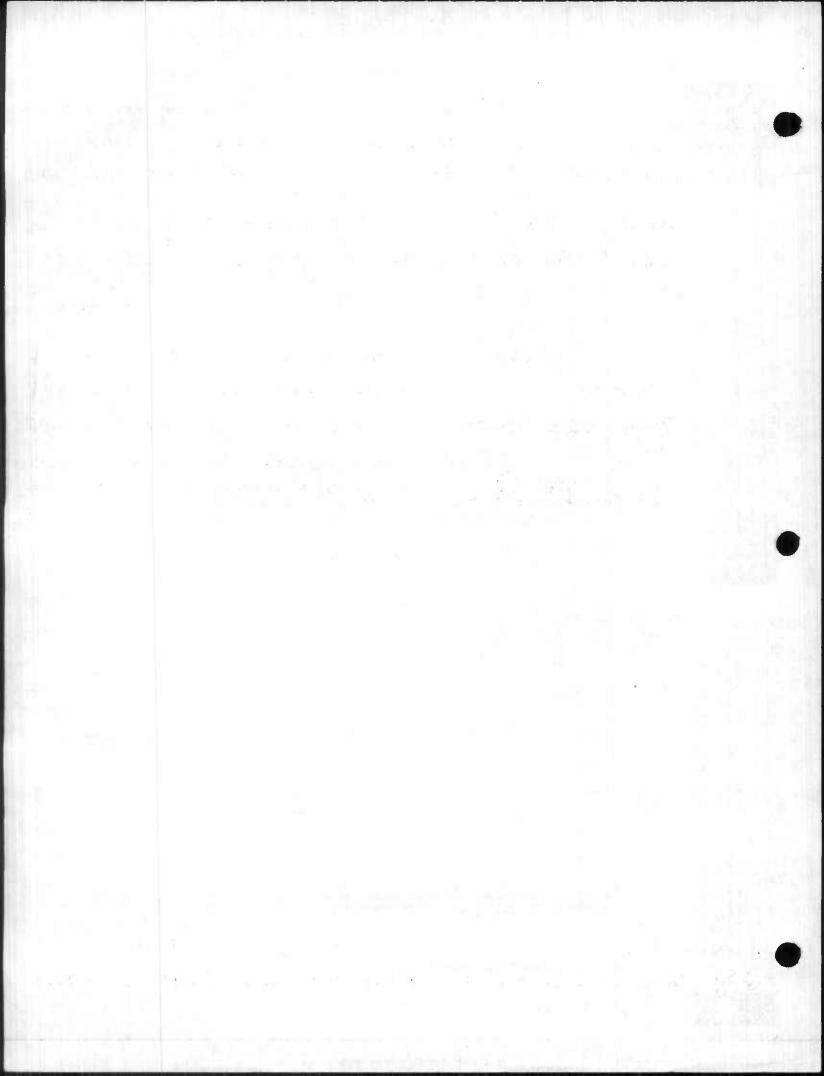
29b. Signature and title of certifier

29c. License number D43725 29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

201-109 Back River Neck Roud Baltimore MD 21221 TARIQ MAHMOUD 31. Date filed (Month, Day, Year) AUG 0 7 2000

State Registrar 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 21,766

MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET M. MARGARET MARGAR	ASON nive street and number	more Age (In yrs. last 81	Yrs.	f Under 1 Year fonths Days	Balti If Under 24	Hrs. 8. Date of	Day Yest 1 200 Peath 4c. County of E	Death Birthplace (State or Fort Country)
Sinai Hospita Sinai Hospita Social Security Number 214-14-4856 Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number 4669 Falls Road 11. Marital Status	ive street and number 1 of Balti Sex 7.7	more Age (In yrs. last 81	Yrs.	f Under 1 Year	Balti If Under 24	Augus , or Location of D more Hrs. 8. Date of (Month)	8t 1 200 eath 4c. County of E N/A Birth Day, Year) 9.	00 10:10a Death Birthplace (State or For
Sinai Hospita Sinai Hospita Social Security Number 214-14-4856 Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number 4669 Falls Road 11. Marital Status	ive street and number 1 of Balti Sex 7.7	more Age (In yrs. last 81	Yrs.	f Under 1 Year	Balti If Under 24	more Hrs. 8. Date of	eath 4c. County of INA Birth Day, Year) 9.	Death Birthplace (State or Fort Country)
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Usual Residence of Decedent 10a. State 10b. County MD N/A 10e. Street and Number 4669 Falls Road 11. Marital Status		10c. City, To						VA
MD 10b. County N/A 10e. Street and Number 4669 Falls Road 1. Marital Status						Tiare	117, 1717	A 127
10e. Street and Number 4669 Falls Road 11. Marital Status			own or Locati	ion				10d. Inside City Lin
4669 Falls Road		Ba]	ltimore	e				1)∑Yes 2□
4669 Falls Road				10f. Zip Code			10g. Citizen of What	I Country?
11. Marital Status				.v. zip 0008			Tog. CRIZER OF WAR	ountry?
					21211		USA	
1 Newer Marriad 2 Marriad	12. Was Deceder Armed Forces	?	13. Was	Decedent of I s, specify Cub	tispanic Origin an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 14. Race · / Black, V	American Indian, Vhite, etc.
	If Yes, Give			Yes 2 No				white
3 M Widowed 4 □ Divorced	Year or Dates	:		3.			Specify.	
15. Decedent's (Specify only highest of		16	(Give kind	t's Usual Occup d of work done	during most of	working	16b. Kind of Busine	ess/Industry
Elementary/Secondary (0-12)	College (1-4o		life. DO	NOT use retire	d)			
12	1 - L - 3 - L Di	2	ad-	juster				urance
17. Father's Name (First, Middle, La.							ldle, Maiden Surname)	
Robert E. Mich	aels				Mab	elle Swa	ats	
19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing A	ddress (Street	and Number o	or Rural Route Nu	mber, City or Town, Sta	te, Zip Code)
Frances Chandlee	/sister	THE PART	4100 N	. Char	les Str	eet #10	002 Baltimo	ore, MD 21
20a. Method of Disposition		20b. Place	of Dispositio	on (Name of		Date	20c. Location - City	y or Town, State
1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spec		e ceme	nery, cremato	ory or other pla	00)	i		
21. Signature of Fundral Service Lic	7		20.11	ame and Add-	nes of Easilia	1		
	Wade, Di	rector	S1	ame and Addre tate An	atomy E	Board 6.	55 W. Balti	more Street
remun	11/11/10	el		altimor		21201		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	b	Due to (or as tension	a consequen		ise			
Lause (Disease of Injury that initiated events resulting in death) Last	C	Due to (or as		ce of):				
Part II. Other significant conditions	contributing to death	but not resulting	g in the under	rtying cause gi	ven in Part I.	23b. (Did tobacco use contril	bute to the cause of de
COPD	H 108/11						□ Yes 2□ No 3[Probably 4 Unkr
COLD								
							Vas an autopsy erformed?	4b. Were autopsy findin available prior to completion of cause of death?
							☐ Yes 211 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical					26 Diego of	Death (Check or	.00	
examiner?	Hospital:	tiont all a	Outpotion	20 DOA ON	hor			Specify)
27. Manner of Death 1 Pratural 5 Pending 2 Accident investigati	28a. Date of In	b. Time of Injury	28c. Inju Wo	4D Nothing Home 5D Pesidence 6 Dottler (Specify)				
E LI PROGRAMIN	be 28e. Place of I	njury - At home, etc. (Specify)	farm, street,			28f. Location	on (Street and Number of Town, State)	or Rural Route Number,
3 Suicide 6 Could not determine			ige, death oc	curred at the ti	me, date and p	place, and due to	the cause(s) and manne	er as stated.
4 Hornicide determine	Invalcian: To the besis	of examination	and/or invest	igation, in my	opinion, death (occurred at the til	ne, uate and place, and	000 (0 1110 00000(0)
4 Hornicide determine	On the basis	of examination	and/or invest	29c. Licens		occurred at the ti	29d. Date signed (A	
4 Hornicide determine 4 Hornicide determine 29a. Certifier (Check only 2 Medical Exp	On the basis	of examination	and/or invest	29c. Licens	se number	occorred at the th	29d. Date signed (A	Aonth, Day, Year)
4 Hornicide determine 29a. Certifier (Check only 2 Medical Example) 29b. Signature and filte of certifier	On the basis and manner s	of examination stated.	and/or investi	29c. Licens		occurred at the ti	29d. Date signed (A	
4 Hornicide determine 4 Hornicide determine 29a. Certifier (Check only 2 Medical Exp	On the basis and manner s	of examination stated.	and/or investi	29c. Licens D00	se number)54482		29d. Date signed (A	Aonth, Day, Year)

Registra

DHMH 16 Rev 6/95

Phys /Me Exan

Funer Directo

> than "natural", or hams 23s or 28s-f show he Medical Examiner must be notified at

Physicia /Medica Examine

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Ronald S. Wader Director

State Anatomy Board 655 Baltimore, MD 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Cassandra Gail Moultrie

State of Maryland / Department of Health and Mental Hygiene

an 1. L	IS: #23 PART I	ot)				2. Date of D	30, Dev2000		3. Tima of Death 7:25 pm		
calC	assandra Spellity Name (If not institution, give	Gai	1	Moul	trie	or Location of Dear			7.23 QII		
ner 4ª	1022 North Payson Street Baltimore N/A										
07	7-44-4321	ex	rs. last birthday) Yrs.	If Under 1 Year Months Deys		in. (Month, D	rth ey, Year)	9. Birthplec	e (Stete or Foreign) Y		
Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 11									Inside City Limits		
ò	MD NA				1 Yes 2 No						
10e	Street and Number	Ба	ltimor	10f. Zip Code			10g. Citizen of V	What Country	?		
	022 North Pay	son Street		21	217		IJ	S.A.			
	Meritel Status	12. Was Decedent Evar in Armed Forces?	U,S. 13. V			(Specify Yas or N arto Rican, etc.)	o- 14. Rac	e - Amarican ck, White, atc			
-	□ Never Merried 2□ Merried	1 ☐ Yes 2 No If Yes, Giva		□ Yes X No			Specify				
	3 ☐ Widowed 4 ☑ Divorced	Yaer or Detas:	10a Danas	landa Hausi Ossu	mating		16h Kind of B	Blac			
Completed	15. Decedent's Ed (Specify only highest gre	de complatad)	(Give	lent's Usual Occu kind of work done DO NOT use retin	during most of	working	TOD. KING OF BI	usiness/maus	ness/Industry		
amo 1	ementery/Secondery (0-12)	College (1-4or 5+)	IIn	Unemployed			linor	employed			
17.	athar's Nema (First, Middle, Last)		UII	ешртоўе	18. Mother's I	Neme (First, Middle			eu		
0	illiam Cummin	as			Sarah	Willia	ms				
	. Informent's Name/Relationship (7		19b. Mailin	ng Address (Stree		Rural Route Numi		Stete, Zip Co	10033		
	rah E. Murray	-Mother	609 1	West 17	4 St.	Apt 301			New York		
20a	Mathod of Disposition Muriei 2 ☐ Crametion 3 ☐	Removal from State	cemetery, cren	sition (Neme of netory or other pl	ece)	Date	20c. Location -	City or Town	i, State		
	4 Donetion 5 Other (Specify	W W		n Cemet		8/5/00	Baltimo	ore Co	bMc		
21.	Signature of Funeral Service Licen	See A	Ma 22	Name end Addr	ess of Facility H West						
	4300 Wabash Ave, Baltimore Md 21215										
23	Part Enter the disease, or companies, or heart lature. List only							In	pproximete iterval Between inset end Death		
Imr	nediete Ceuse (Finei	CHRONIC ALCOHOLISM COMPLICATED BY DILATED CARDIOMYOPATHY AND FATTY LIVER									
dis	pese or condition ulting in deeth)	θ			лтх ГТ	VER					
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	uentielly list conditions, by, leeding to immediate se. Enter Underlying se (Diseese or injury										
O I IIIe	initieted events Ilting in deeth) Lest	Due to	Due to (or es e consequence of):								
		d									
10					9 76						
Physician/M	II. Other significant conditions of	nfributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of deat				
						_ 1L	Yes 2 No	3 Probat	bly 4 Unknown		
Completed by						24a. Wa	s en eutopsy lormed?	availe	eutopsy findings able prior to		
								of de	plation of cause ath?		
						1	Yes 2□No	1/20	res 2□ No		
25.	Was case referred to medical examiner?	D%-1				Deeth (Check only	one)				
	1 XYes 2 No	-	ER/Outpatier	I JLI DOA		g Home 5 Res			t scene		
0	Menner of Deeth ∑Neturel 5 □ Pending	28e. Dete of Injury (Month, Dey Year	28b. Time of Injury	W		260. Describe	how injury occur	red			
Ca	2 Accident Investigation 3 Suicide 6 Could not be		M 1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, factory, office 28f. L					281. Location (Street end Number or Rurel Route Number,			
Certification:	4 Homicide determined	building, etc. (Spe	ecify)				own, Stete)				
		ysicien: To the best of my liner: On the basis of exam									
8	Signature and fitia of certifier	and menner steted.		29c. Licer	nse number		29d. Date signe	ed (Month, Da	ıy, Year)		
≥ 29b	1 /1			0	.C.M.E.			31, 20			
≥ 29b		U No	0	0	· C · L L · D ·		UCLLY	21/ 20			
	Name and address of bareon who	completed cause of death !!	tem 23a) (Tuno					31, 20			
	Name and address of berson who of the ARV G. R.	completed cause of death (I		Print)	.1	altimore,					

XX at sc

E.

set, Balti

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OL 2000 John Albert Merwitz 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltware | Birth | B. Date of Birth | Month, Day, Year) Sival Houpital 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 10(M 2□ F Yrs. 254-64-4500 AUG 23, 1942 New York Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ➡ No Maryland Baltimore Randallstown 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 3511 Chapman Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Sfatus t Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes QUNo 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Merwitz Ruth Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8049 E. DesMoines St. Mesa, Arizona 85 ca of Disposition (Name of Date 20c. Location - City or Town, State Dave Merwitz/Son 85207 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc.8-2-00 Baltimore, MD 21. Signature of Fugieral Service Licen 22. Name and Address of Facility Cremation Society of MD, Inc. re orchik 299 Frederick Road Baltimore, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Edward MD 21228 23a. Part1. Enter the disease, or the shock, or heart failure. List or Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zhrs LUD COS CUIDINA Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 70s 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avaitable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No

Physician /Medical Examiner

P.O. Box 68760.

of Vital Records,

Division

lepartment of Health reportant: If Item 27

Physician

/Medical

Examiner

Director

Funeral

Director

8 Norna 23a

8

Physician/Medical Examiner Be Completed by Medical Certification: To

The law requires that the death certificate be execu ai or Attending Physician: The safter death.

It Director: After this certificated in by the funeral director, pa filled in by To the Hospital within 24 hours a To the Funeral D

State

Registrar

29b. Signature and title of certifier lute, p.O

5 Pending investigation

6 Coutd not be

29c. License number 259 000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Paltimore MD ZIZE

1 Yes

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, Stete)

august, of

2000

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

PALLAVI SHAH, D.O. 31. Dafe filed (Month, Day, Year)

25. Was case referred to medical

1 Yes 2 No

27. Menner of Death

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

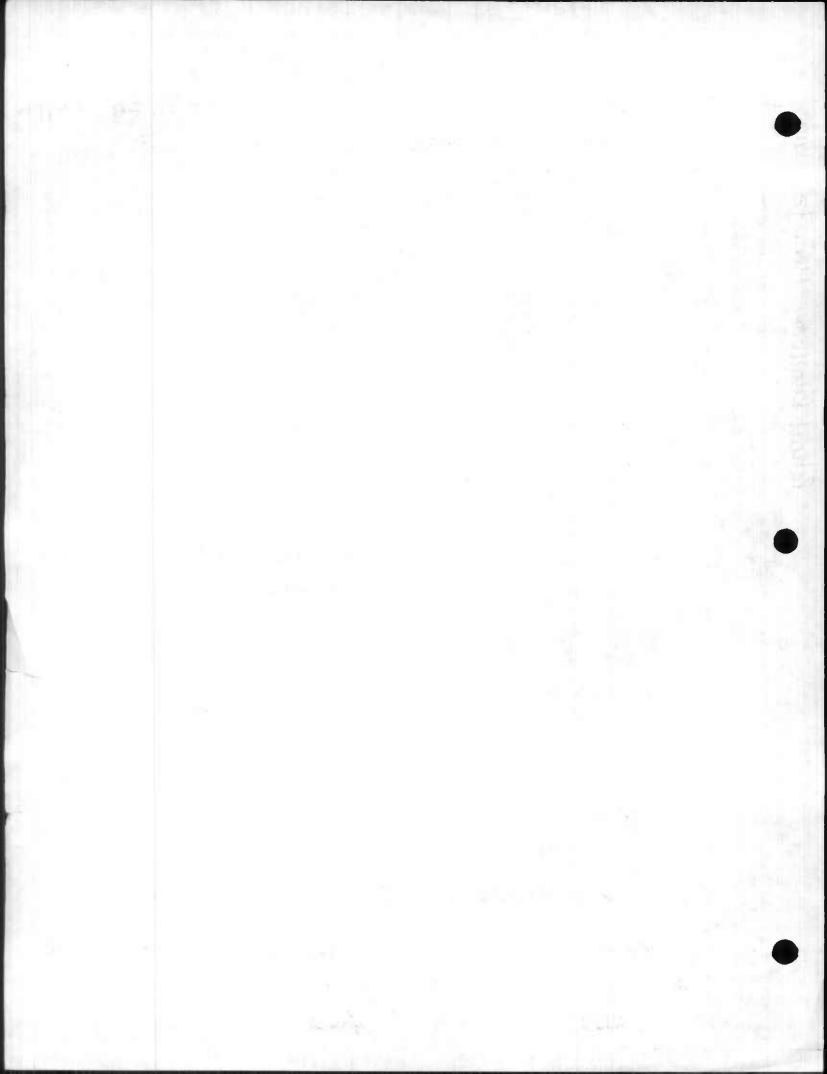
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

DHMH 16 Rsv 6/95



Baltimore, Maryland 21215-0020

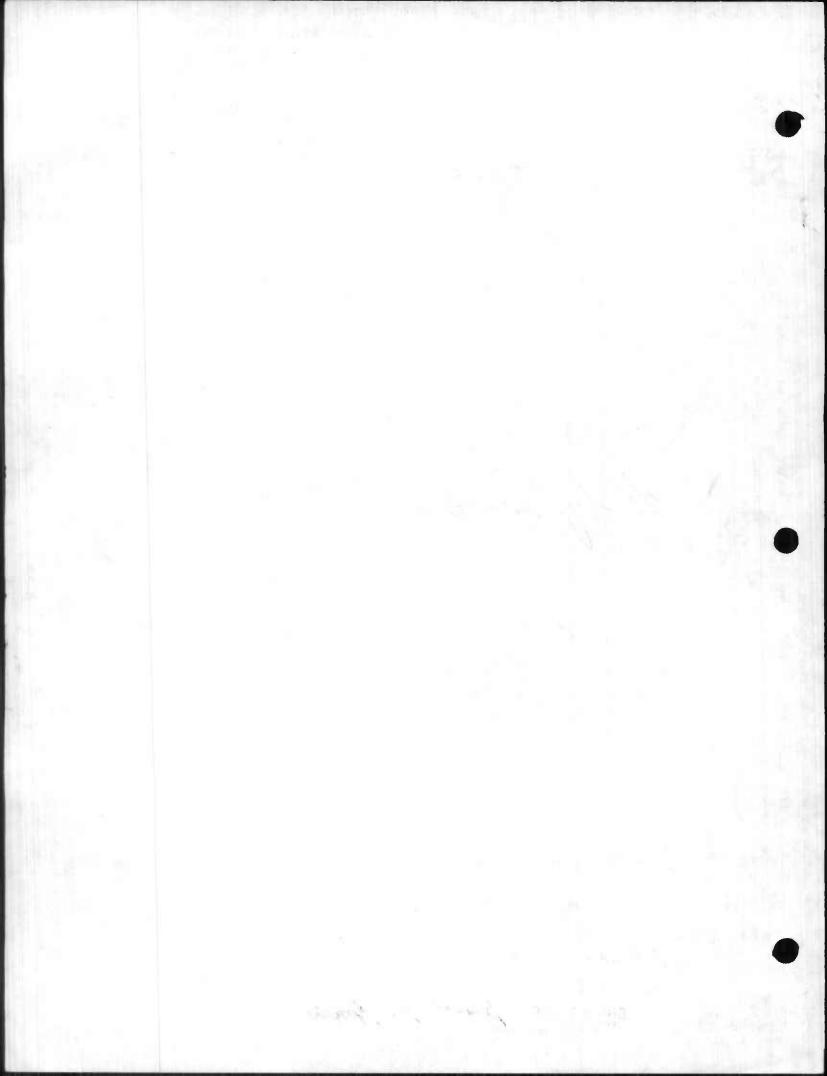
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

dra Marti AMEND ITE	ma MS: #23 PART I, 27,	State of Mary	land / E		Health and	Mental Hyg		0 24769			
	1. Decedent's Name (First, Middle, Last)			00/11/10410	., 5000.	2. Dete of Dear	eg. No.	3. Time of Death			
Physician	Sandra De'borah Mo	Knight Mar		Month July 27	Dey 2000	Yeer 8:11 am					
/Medical Examiner	4e Fecility Neme (If not institution, give s		Location of Deeth	4c. County							
	Bon Secour Hospital	1	Baltimon	re	N/A						
Funeral Director	216-38-2421	M 2 F 7. Age (In	par If Under 24 Hrs. ys Hours Min.								
pur k	Usual Residence of Decedent 10a. State 10b. County	100			10d. Inside Otty Limits						
Maryl f sho led a	MD N/A		Balti								
or 28s-4 a be notified Director	10e. Street and Number		Darci	10f. Zip Cod	e	1	/het Country?				
	1510 Mosher St	Apt. #3N		2121	7		USA				
flar death v flar met finer met		2. Was Decedent Ever Armed Forces?	in U,S.	13. Wes Decedent	of Hispenic Origin? (S Jupan, Mexican, Puerl	specify Yes or No-		a - American Indian, k, White, etc.			
aff. or its Examina by Fu	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Detes:		1 Yes 2 1		to ritouri, etc.,	Black				
T2 ho	15. Decedent's Educ (Specify only highest grade	ation	16a.	Decadent's Usuel Oc	t's Usuel Occupation			siness/industry			
ud within 72 ho ygiene. we then "natur it, the Medical Completed	Elementery/Secondary (0-12) 12th	College (1-4or 5+)		life. DO NOT use rel Housewife	ne during most of wortired)	Ning	Domest	ic			
be filed d other event.	17. Fether's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, I					
Wenter Had the street	Jesse McKnight				Francis	s Fields					
and land	19e. Informent's Neme/Reletionship (Typ	oe, Print)	19b.	Mailing Address (Str.	eet end Number or Au	Rural Route Number, City or Town, State, Zip Code)					
and m 27 her tr	Cassandra A. Harp				prview Rd.			21229			
I the room	20e. Method of Disposition 20b. Place of Disposition (Neme of cemetory, cremetory or other place) 20c. Location - City or Town, State										
tant: dury	4 Donelion 5 Dother (Specify) Sacred Heart Cemetery 108/04/00 Germantown, MD										
Departiment important impo	21. Signature of Plinese Service Cicense	1/	4	Chavis Baltimo	Funeral H	ome, PA, 1231 - (4	2007-09	Eastern Ave.			
	23a. Pall1. Enter the disease, of complice shock, or heart failure. Ustonly one	cations that caused the	Math Do n		dying, such es cardia			Approximete Interval Between			
Physician	and, or their later by by the							Onset end Death			
/Medical Examiner	Immediate Ceuse (Finel disease or condition	/	CIRRH	OSIS OF TH	HE LIVER						
	resulting in death) e.	Due									
executed and iel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due		17.00							
buricia be	cause. Enter Underlying Cause (Disease or injury that initiated events	THE STREET									
eath certificate ettending physic and for use as the clan/Medic	resulting in death) Lest	Due									
nding use e	d.				A Carl						
death e etter e otter e siciar	Pert II. Other significant conditions cont	ribution to death but no	23b. Did to	23b. Did tobacco uss contribute to the cause of death?							
that the led by the detached b				1 Yes 2 No 3 Probably 4 Unknown							
The lew requires age hes been significate hes been significate by Completed by			24a. Wes e	a. Wes en eutopsy performed? 24b. Were eutopsy find aveileble prior to completion of cau							
hes to				of		of deeth?					
		1 Yes 2 No 1 Yes 2 No									
	25. Wes case referred to medical examiner?	ospitel:	• 17 50 10	100 Do	Other:	eth (Check ohly or					
Physeral di	1XXYes 2 No 27. Menner of Death	28a. Dete of Injury	28b. T	ime of 28c. I		lome 5 ☐ Reside		***			
ath. Afte	1 X Neture 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Ir	Ib. Time of Injury et Work? M 28c. Injury et Work? 1 Yes 2 No							
tal or Attending P rs after death. al Director: Attent led in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				28f. Location (S. City or Town		er or Rural Route Number,			
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:		iclan: To the best of my er: On the basis of exa						nner es stated. and due to the cause(s)			
of the of the omple	29b. Signeture and title of certifier	end menner steted.	111	29c. Lic	ense number	2	9d. Dete signed	d (Month, Day, Year)			
£ ≱ £ 8	Theoly U	1 Kink	no		C.M.E.			8, 2000			
	30. Neme end eddress of person who con										
	AttopopEM, KI	ug	111	Penn Stre	et, Baltin	nore, Mar	yland 2	1201			

Registrar

AUG 0 7 2000 32. Registrer's Signatu



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Margaret Morgan ueus1 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Belcamp Lorien Riverside Nursing Home HARFORD If Under 24 Hrs If Under 1 Year July 30, 1919 7. Age (In yrs. last birthday) Funeral 1 M 2 F Months Deys Hours 81 213-18-1731 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Baltimore MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2524 Canterbury Road 21234 U.S.A. 12. Wes Decedenl Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No MARGARET "natural", or Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secreterial Board of Education permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygil Important: If Item 27 is marked other. any Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown Unknown 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jennifer Morgan-Granddaughter 6 Capella Ct. Baltimore, Maryland 21237 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Gardens of Faith Cemetery 8/5/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each lina. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner consequence of) physicien and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventaresulting in death) Last Due to (or es e consequence of): Due to (or es e consequenca of):

The lew requires that the deeth certificate be executed Box 68760. US0 08 P.O. Records.

of Vital

Division

Physician/Medical Examiner à Be Completed

pega 2 s Certification: To this funeral Aftar or Attending a after design Atractor: Aftr

To the Hospital of within 24 hours of To the Funeral D completely filled is Medical State

Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical axaminer? 1 Yes a No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation Natural 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide

4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(s) end menner es steted.

The best of my knowledge, death occurred at the time, data end place, and due to the ceuse(s) end menner es steted. 29b. Signature and title of portifie

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28c. Injury at Work? 1 Yes 2 No

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

1 Yes ZONo

2 DNO

24a. Wes en eutopsy performed?

26. Placa of Death (Check only ona)

29c. License number

29d. Date signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death?

Yeer

2000

Maryland

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximate Intarvel Between Onset end Death

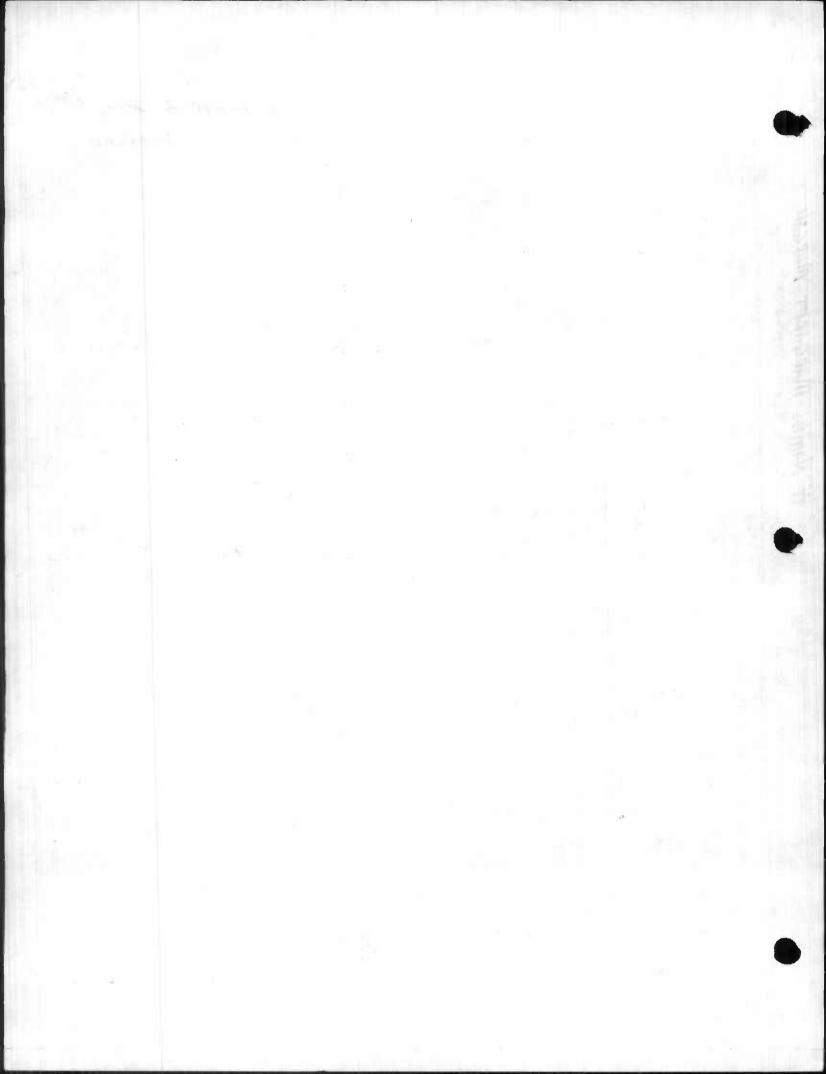
3 Probably 4 Unknown

24b. Were eutopsy findings aveileble prior to completion of cause of death?

1 ☐ Yes 2 🗓 No

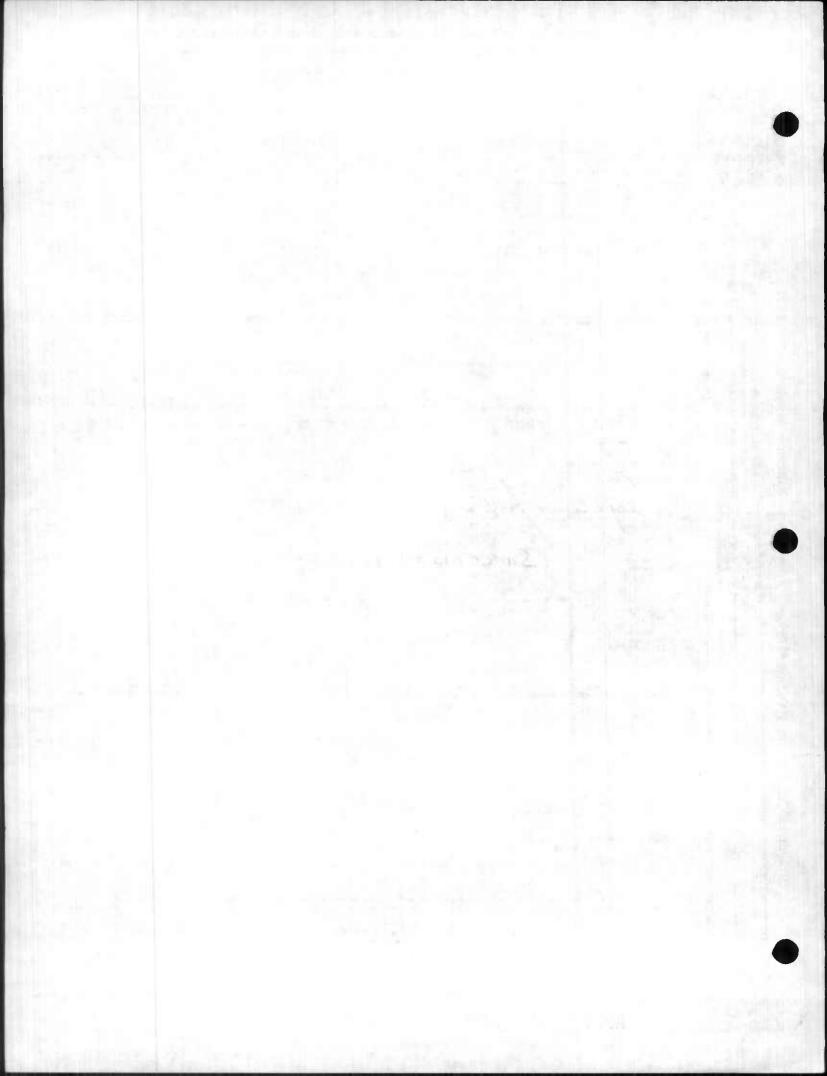
30. Name and address of person to the second to completed cause of death (Item 23a) (Type, Print) 1016

31. Date filed (Month, Day, Year) AUG 0 7 2000 32. Registrar's Signeture Marie



State of Maryland / Department of Health and Mental Hygiene 00 2477

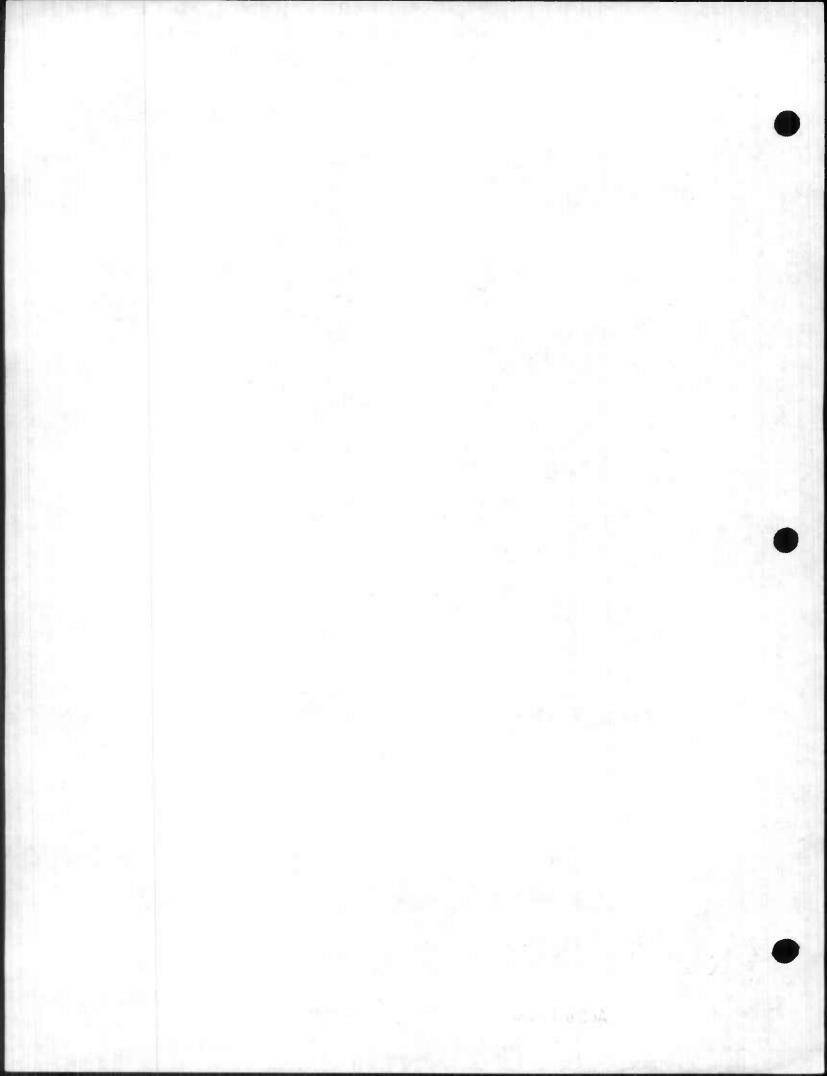
							Ce	rtifica	te of	Death			Reg. No.	00	6	+111
			1. Decedent's Nem-	e (First, Middle, La	st)			7.1				2. Dete of De	ath	ν.		3. Time of Death
	Physicia	_		ROSE			M	AZER				Month AUGUST	3, 2	000 Ye	ar	2:20 AM
	/Medica	_	4a Facility Name (/	f not institution, giv	e street and number	or)				4b. City, To		ocation of Death	- 1	County of D	Death	2.20 111
	Examini	71	PIKESV	ILLE NURS	SING HOME					BALT	TMOR	E	B	ALTIM	ORE	
-	Funeral		5. Social Security N			Age (In yrs. I	est birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Bird (Month, Da				ce (State or Foreign
	Director		212-07-0	0120	□ м 20ХЕ	92	Yrs.	Months	Days	Hours	Min.	APR.18,	1908		Country	MD
	pu *	1	Usual Residence of 10a. State	10b. County		10c. City	. Town or Lo	ocation							100	I. Inside City Limits
	aho a	5	MD	BALTIMO	ODF			IMORE	,							1 ☐ Yes 25 No
	The N	Director	10e. Street and Nur				DAUL						10a Citis	en of What	Caunta	41
				COURT RO	DAD #311			101. 21	p Code	2120	8			.S.A.	Country	
	theme theme	Funeral	11. Meritsi Status		12. Was Deceder Armed Force	nt Ever in U, s?	S. 13.	Was Dece	edent of H	lispenic Ori an, Mexicar	gin? (Sp	ecify Yes or No Ricen, etc.)	- 1	4. Rece - A Bleck, V		
020	urs efte	þ	1 ☐ Never Marri 3 🏿 Widowed	ied 2 Married 4 Divorced	1 Yes 25 If Yes, Give Year or Date:	No		1□ Yes						Specify:		WHITE
		Completed	(Spec	15. Decedent's Ed			16a. Dece	dant's Usu	al Occup	pation during mos	t of work	ring	16b. Kin	d of Busine	ess/Indu	stry
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and	2 0 0 ×	Be	17. Father's Name	Pirst, Middle, Last)						18. Moths	rs Nam	a (FITSE, MIDDIE,	wawan s	Surnama)		
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6	f Health frem 27 l	-			DAUGHTER	non D	400 lace of Dispo			TREET	#6F	- NEW		oation - City		
altimor	80				Removal from Star	te Co	emetery, cre	matory or	other pla		8	Data /4/00		ALLST		
alti	orte Inju	1	21. Signature of P							ess of Fecilit	v					
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		+	23a. Parti er ter ti	of disease or com	obations that caus	ed the death	Do not en	ter the mo	de of dvi	ERSTO	cardiac	OAD - P	TKES	VILLE	1	Approximate
	Dia . / . /		shock or hea	failure. List only	che dauge un each	line.									. 1	ntarvel Between Onset and Deeth
ال	Physician		immediete Ceuse (Finel	-		, ,						1-			/
	Examiner		disease or condition rasulting in death)		. Sara	com.	a told	Ca	1/6	NOW	14	of u	4/	-45		1 year
		ē				Due to (or	as a conse	quence of):							
	d ansit	Examine	Convention to the		b	or as a consequence of):										
ó	death certificate be assouted e attending physician and od for use as the burial-transit	EX	Sequentially list con if any, laading to irr cause. Entar Unde	imediate	Due to (or as a consequence or):											
68760,	sicia bu	edical	cause. Entar Unde Cause (Disease or that initiated events		c	Due to (or	es e conse	nuence of)	•							
68	ing phy e as th	8	resulting in death) Last Due to (or es e consequence of):													
Box	attendin for use	2	d												-	
m	d for	2	Part II. Other signif	icent conditions o	ontributing to death	but not ron	ulting In the I	ındadvina	cause ai	van in Part I	_	23h Did	tobacco	use contrib	bute to t	he cause of death?
0	the the	Physician	raitii. Oulei sigiiii	carr conditions c	onthousing to death	DUL HOL 1650	inting in the c	anderrying	cause gr	V 2011 111 1 1 (2.1), 1				-		ibly 4 Unknown
<u> </u>	E 90	Dy P											100 24	# 140 OL		ibiy 4 di omanown
Records,	v requires been sign should be											24e. Was	an autop	sy 2	avail	e autopsy findings lable prior to pletion of ceuse
3ec	hes b	Completed														eath?
=	cate he	3										10	Yes 2	No	10	Yes 2□ No
Vital	certificate rector, pag	20	25. Was case reference examiner?	red to medical	Hospital:				Ott		of Deat	th (Check only	ona)			
o	hys his	0	1 Yes 2		1 L Inpa		ER/Outpatie			4 KINI	rsing Ho	ome 5 Resi			Specify)	
	Ing P	0	27. Manner of Death 1 2 Natural	5 Pending	28a. Data of In (Month, I	Day Year)	28b. Time of Injury		28c. Inju Wo			28d. Describe	now injury	occurred		
sic	Attending or deeth. ector: Afte fune	cat	2 Accident 3 Suicide	invastigation				М		Yes 2	No	004 1	C11	136 5	D 1	S
5	al or Attending Pi s effer deeth. Il Director: Affer the ed in by the funera	Certification:	4 Homicide	determined	28a. Place of	Injury - At ho etc. (Specify	ma, farm, st	reat, facto	ry, office			28f. Location (City or To			or Hurai	Houre Number,
		edical	29a. Certifier (Check only one)		ysician: To the besinner: On the basis	of examinat										
	ithin mpl	Σ	one) end manner stated. 29c. License number 29d. Dete signed											e signed (A	Month, D	ay, Year)
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		-	1/			_		1	D002	29064			Augu	st 3,	200	00
	0		30. Name and addre													
			Jerome H.				Liber	ty P	laza	Mall	Ra	andallst	own,	MD 2	2113	3
	Stat Registra	_	31. Dete filed (Mont	th, Day, Year)	OOO 32. Hegis	strar's Signal	Lure	1 1	pou	Ks						



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giene	00	2	L,	7	7	1
Bea No.					ž.	

			Cert	tificate of	Death		leg. No.	9 4	7116					
Dhusisian	1. Decedent's Neme (First, Middle, Last)				2. Dete of Dee	th Dey	Year	3. Time of Death					
Physician /Medical	Ursula Naidicius					august	3, 2000		19:55					
Examiner	4e Facility Neme (If not institution, give St Agnes Hospital				4b. City, Town, or L Baltimor		4c. County N/A	of Deeth						
Funeral Director	213-30-1003	X 7. Age (In yrs.	18 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De)			ce (Stete or Foreign uania					
2	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Ci	ty, Town or Loc	ation				10d	I. Inside City Limits					
in the Maryland or 28a-l show a notified at	Maryland Baltimo		ltimore		Part.				1 ☑Yes 2 ☐ No					
2 m 42 tes	10e Street and Number 1226 Ten Oaks Road			10f. Zip Code 21227			IOg. Citizen of V USA	Vhet Country	17					
5-0020 72 hours after death v natural; or therre 23s sted Examiner must		12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:		/as Decedent of P Yes, specify Cub ☐ Yes 2 ☐ No	dispenic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blee Specify	American k, White, etc	C.					
1 21215-0 ad within 72 ho typiens wr than "naturit, the Medical.	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)		16e. Decede (Give k life. D	ent's Usual Occup ind of work done O NOT use retire	petion during most of work d)	ing	16b. Kind of Bu		stry					
21 21 21 21 21 21 21 21	4th	0011090 (1 401 04)	Seamst	tress			Factor							
Maryland 21215-0020 d2 should be filled within 72 hours all and Mental Hygiene. 77 is marked other than "natural", or 1 traumatic event, the Medical Exami To Be Completed by F	17. Father's Name (First, Middle, Last) Viktoras Venslovas				18. Mother's Nam Unknow		Maiden Sumem	e)						
send 2 short set and 2 short series and 1 series and 1 series and 1 series are traument traument.	19a. Informent's Name/Relationship (T) Donna Kicas/Daught				end Number or Rui									
Ore Fred H	20e. Method of Disposition 1 Surial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) Meadowridge Memorial 8/7/00 Elkridge, Maryland													
Baltim permit. Pa Department Important any Injury ense.	21. Signature of Funeral Service licansee About 1. Weber Funeral Homes, P.A. 5311 Edmondson Avenue, Baltimore Maryland 21228													
-	1 1 1 1	icetions thet caused the dea		11 Edmon	dson Aven	or respiretory er	cimore N rest,	A	Approximate					
Physician	shock, or heart failure. St only o							C	ntervel Between Onset and Death					
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nsit ted								i						
68760, ificate be executed gphysician and ss the buriel-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es a consequence of): Due to (or es a consequence of):													
	Due to (or es e consequenca of): d.													
O. Box he death cert the ettendin hed for use	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to													
S, P.O. es that the de igned by the be deteched by Physic	Breast	cancer				10	/ee 2□ No	3 Proba	bly 420nknown					
cord requir been s should						24a. Wes perlo	en eutopsy med?	avail	e eutopsy findings able prior to pletion of cause eath?					
The law te hes sage 2						101	es 30No	10	Yes 25 No					
	25. Wes case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)							
hystonis construction	1 Yes 2 PNo	lospitel: 1 Inpatient 2	@R/Outpatient	3LI DUA		ome 5 Resid	ence 6 Oth	er (Specify)						
Vision C Attending Pi or death. Or the the til by the funeral	27. Manner of Death 1 Abetural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury		ry et rk? Yes 2 No	28d. Describe i	ow Injury occur	red						
Division N or Attending I pirector: After d in by the tune Certification	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	ome, farm, stre	et, fectory, office		28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rurel I	Route Number,					
Division Completely filled in by the funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the besis of examina end menner steted.	owledge, deeth	occurred et the ti estigation, in my	me, date end plece, opinion, death occur	end due to the red et the time,	ceuse(s) end mo date end place,	enner es stel end due to t	led. he ceuse(s)					
To the within to the comple	29b. Signeture and title of certifier	11 /	1	29c. Licen	se number		29d. Dete signe	d (Month, De	ay, Year)					
2 ==	Mha	MON!	mV	DI	00533	12 /	Augus.	+ 3,	2000					
w. d.	30. Name and address of person who co	empleted cause of death (Item), MD 900 Co.	m 23a) (Type, F	Print) enue,	00533 Balti.	nore,	MO							
State	31. Dete filed (Month, Dey, Yeer)	32. Registrar' Signa			ocks									
Registrar	AUG 0 7	2000 Dene	/	- John										



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	amend i	tem	5 per fh G786 8/23/00 yg	Certificate of Death	Reg. N	
	Physici	an	1. Decedent's Name (First, Middia, Last)		2. Date of Death Month	3. Time of Death
N	/Medic	al	William Owens	4b. City, Town, or L	Hugust	1 2000 8 pm
첿	Examir	er	4a Facility Name (If not institution, give street and number) Bom Secours Hospital		MORE	A)/A
1	Funeral		5. Social Security Number 6. Sax 7. Aga (In yrs. last birth	nday) If Under 1 Year If Undar 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign Country)
L	Director	-	Usual Residence of Decedent	rs.	JAN. 23,1	941 MARYLAND
	ehow et et		10a. Stata 10b. County 10c. City, Town	or Location		10d. fnsida City Limits
	Se-f e	Director	MARYLAND NIA	BALTIMORE		1, 1 Yas 2□ No
	with the	Dir	10e. Street and Number	10f. Zip Code	/ 109. 0	Citizen of What Country?
	deeth with the Meryland rms 23a or 28a-f ehow	Funeral	2/2/DRUD HILL A VENU 11. Marital Status 12. Was Dacedent Evar in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yas, specify Cuban, Mexican, Puarto	ecify Yes or No-	U.S.A. 14. Race - Amarican Indian,
5-0020	ours after al', or he	by	1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forcas? Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Specify: BLACK
15-(Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
2121	be filed within stal Hygiene. Id other than avant, the Mar	omo	Elementery/Secondery (0-12) College (1-4or 5+)	NSTRUCTION WOR		HITING-TURNER CO
Pul	tal Hygid d other evant, th	Be	17. Fafhar's Nama (First, Middla, Last)	18. Mother's Nam	a (First, Middle, Maid	
aryla	Merke	70		Mailing Address (Street and Number or Rui		(MN-UNKNOWN)
Ma	and 2 sho aith end 27 ie ma er treum					TO, MD. 21216
ore,	-155		20a Method of Disposition 20b, Place of	Disposition (Name of , crematory or other place)		Location - City or Town, Stata
altimor	permit. Peges Department of I Important: If its any Injury or o		4 Donation 5 Other (Specify) AR BU	TUS CEMETERY!	8-7-00 B	ALTIMORE, MARYLAND
Bal	permit. Pe Departman Important: any Injury pnce.		21. Sphalule of Furscal Series Lonnies	22. Name and Address of Facility BR	OWN JR	FUNERAL HOME
'n			23a. PANT. Enter the disease, or complications that caused the death. Do n spock, or heart failure. List only one cause on each line.	2140 N. FULT	ON AVE.	BALTO, 146. 21211
	Physician		s∯óck, or heert failure. List only one cause on each line.			Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. metastatic	tumor to e	yer o	xud:
		e.	Due to (or as a c	onsequence ot):		
	be axecuted sician and burial-trensit	Examiner	Sequentially list conditions, b. Mauga av Due to (or as a c	onsequence of):		
60,	ficate be axecuted physician and s the burial-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	ites		
68760,	phy:	edical	resulting in death) Last			
Box		M/VI	d. Chronic	alcoholism	The state of the s	
	law requires that the death certi es been signed by the attending s 2 should be detached for use e	Physician/M	Part II. Other significant conditions contributing to death but not resulting in	the underlying causa given in Part I.	23b. Did tobac	co use contribute to the cause of death?
P.0	that the de ed by the detached		History of Intravenous	s drug abus	1 □ Yes	2□ No 3 Probably 4□ Unknown
of Vital Records,	w requires that been signed is should be det	pd by) 0	J	24a. Was an au	
900	aw rec	plet			performed'	available prior to completion of causa of death?
E B	The eta h	Completed			1 ☐ Yes	2 No 1 Yes 2 No
Vita	Physician: The this certificets and director, par	o Be	25. Was case referred to medical examiner?	Other	th (Check only one)	
	Phys ral di	-	27. Menner of Death 28a. Date of Injury 28b. T	me of 28c. Injury at	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify) njury occurred
lon	Attending For death. Sector: After by the funer	ation	2 Accident investigation	jury Work? M 1 Yes 2 No		
Division	- 2	Certification:	3 ☐ Suicide 4 ☐ Homicida Could not be determined 28e. Placa of fnjury - At home, far building, etc. (Specify)	m, straat, factory, offica	28f. Location (Street City or Town, Str	and Number or Rural Routa Number, ate)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, and the basis of examination and end manner stated.	death occurred at the time, date end place, for investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) end menner as steted. Ind place, and due to the cause(s)
	within To the	Me	29b. Signature and title of certifier	29c. Licansa number	29d. [Data signed (Month, Day, Year)
	Tree !		My relieus	D18327	8	3/2/00
	13	1	30. Name and address of person who completed cause of death (Item 23a) (1 10 1.11	M -	Ballo M 21219
	Sta		31. Date filed (Month, All Feet 7 200) 32. Registrar's Signature	4660 Wilkens	Ave 201	Sano My 21ch
	Registr		Beneva	61		
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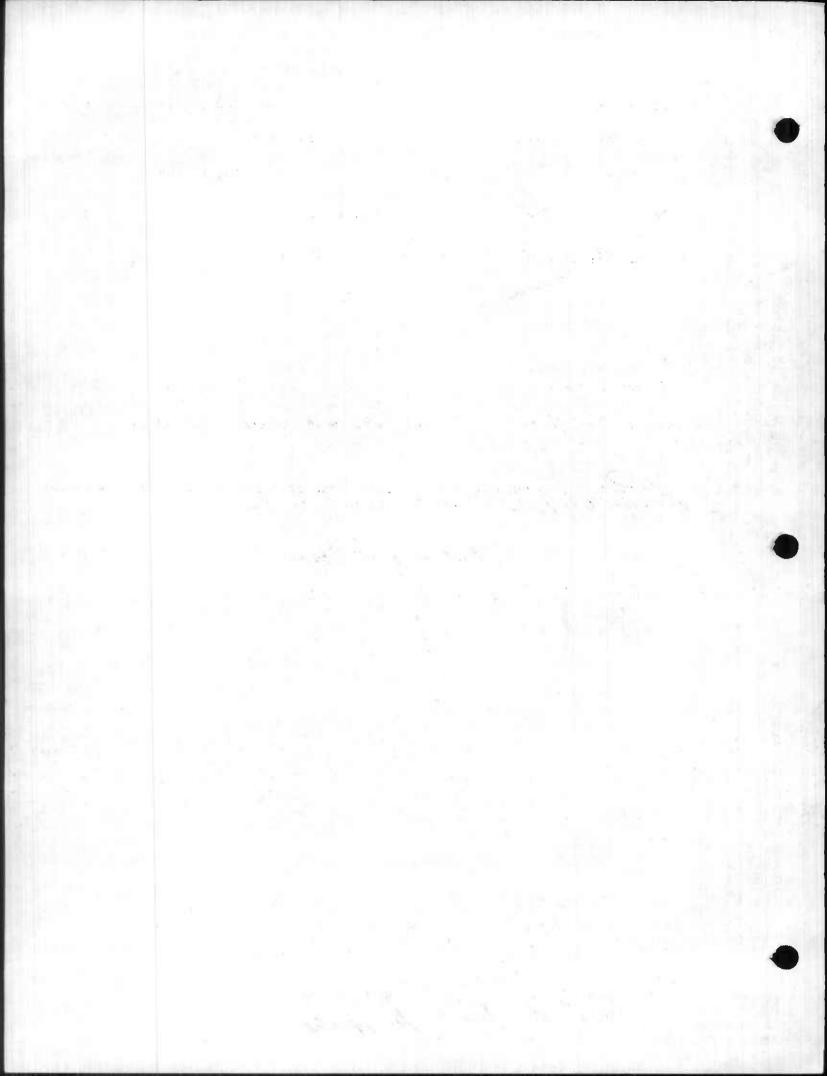
ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Name (First, Middle, Lest) JULY 14, Day 2000 **Physician** ESTHER PARKER 3:58 AM * /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harborside Healthcare Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2\ F Days Hours Min Yrs 219-16-6152 93 Aug 4, MD **Director** Usuel Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD N/A Baltimore 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4700 Harford Road death Funeral 21214 14. Raca - American Indian, 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiena. Important: if fem 27 is marked other than "natural", or frem any injury or other traumatic event, the Medical Exercises and Box. Bieck, White, etc. 1 □ Nevar Married 2 □ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ※ No Specify: Specify: black by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) unk unk 18. Mother's Neme (First, Middle, Maiden Surnema) 17. Father's Neme (First, Middle, Last) Thomas Mitchell Bertha V. Thornton 0 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Baltimore, MD 21214 Harborside Healthcare 4700 Harford Rd 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Ramovai from State 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name end Address of Facility Konald S. State Anatomy Board 655 W. Baltimore Street nan Baltimore, MD 21201 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, nock, or heart failure. List only one cause on each line. Approximete Intervei Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) CANCINO H 99 Examiner Examiner physician end s the burial-transit the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es a consequença of) 80 950 ٥ signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3/2 Probably 4 Unknown Division of Vital Records. p 24b. Were eutopsy findings aveileble prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed peeu has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medicai (Check only one) 2 Medicat Exam To the I within 2 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 30. Nema and addrass of person who cause of death (Item 23e) (Type, Print) 26 OU 2000 State AUG

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Vesi 2000 135 P.M. LORIA KICE TUL 30 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARIS HOSPICE TIMONIUM BALTIMORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) **Funeral** Days Months 10 M 20 F JULY 13, 1949 SOUTH CAROLINA 216-54-3959 Director Usual Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 1244 NORTH AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) USA,
Race - Amarican Indian, Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, Whita, atc. 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1□ Yes 2K No Specify: by 3 ☐ Widowed 4 ☐ Divorced ACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry ith and Mental Hygiena. 27 ie marked other than "r r treumatic avent, tre Hea Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) 8 Pages 1 end 2 should be nent of Heelth and Mental HENRY ARELEE MCTEER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Important: If Item 27 is eny injury or other tre DDCs. 906 CHESTNUT HILL AVE SISTER BALTO, MD. 21218 THOMAS ANN RICE Baltlmore, 20a. Method of Disposition

| Serial | 2 | Cremation | 3 | Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, State **Department** GREENMOUNT CEMETERY 8-5-00 4 □ Donation 5 □ Other (Specify) BACTIMORE, MARYLAND 22. Nama and Address of Facility
JOSEPH H.
2140 N. FUL 21. Signature of Funeral Service Lipense BROWN JR. FUNERAL HOME H. BROWN JK. FUNERIL ITE FULTON AVE. BALTO. MD. 212 Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or raspiratory arrast shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician /Medical Immediata Causa (Finat diseasa or condition rasulting in death) . CANCER OF ESOPHAGUS Examiner Due to (or as a consequence of): Examiner icien end burlei-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) physicien s the buriel Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? The law page 2 1 Yas 2X No 1 ☐ Yas 2 ☐ No VItal certificata Attending Physicien: director, Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA oto this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After Division 5 Pending 1 Naturat deeth. 1 Yes 2 No ne Hospital or Attendi n 24 hours after deeth ne Funeral Director: / pletely filled in by the I investigation 2 Accident 6 ☐ Could not be detarmined 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the Vithin 2 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) ION 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) W DR. TARIQ MAHMOOD 2300 DULANEY, VALLEY RD. TIMONIUM, MD 21093

DHMH 16 Rev 6/95

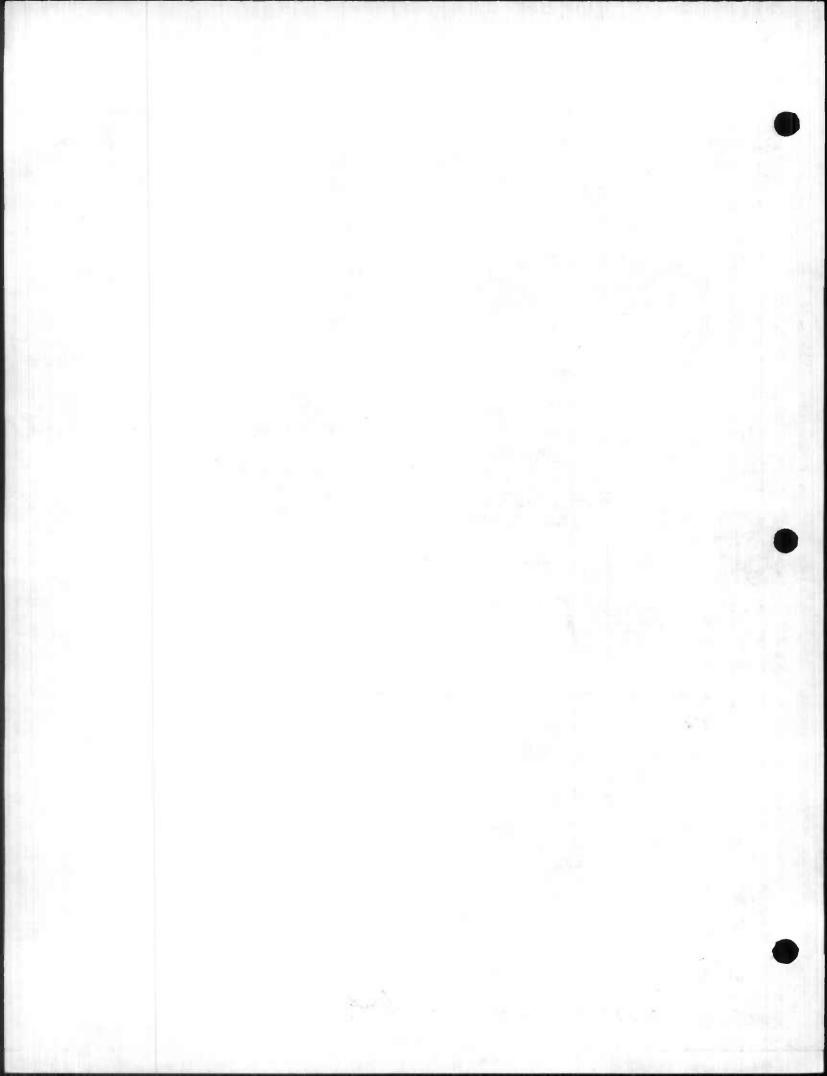
State Registrar 31. Data filed (Month, Day, Year) AUG 0 7 2000

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32. Registrar's Signatu



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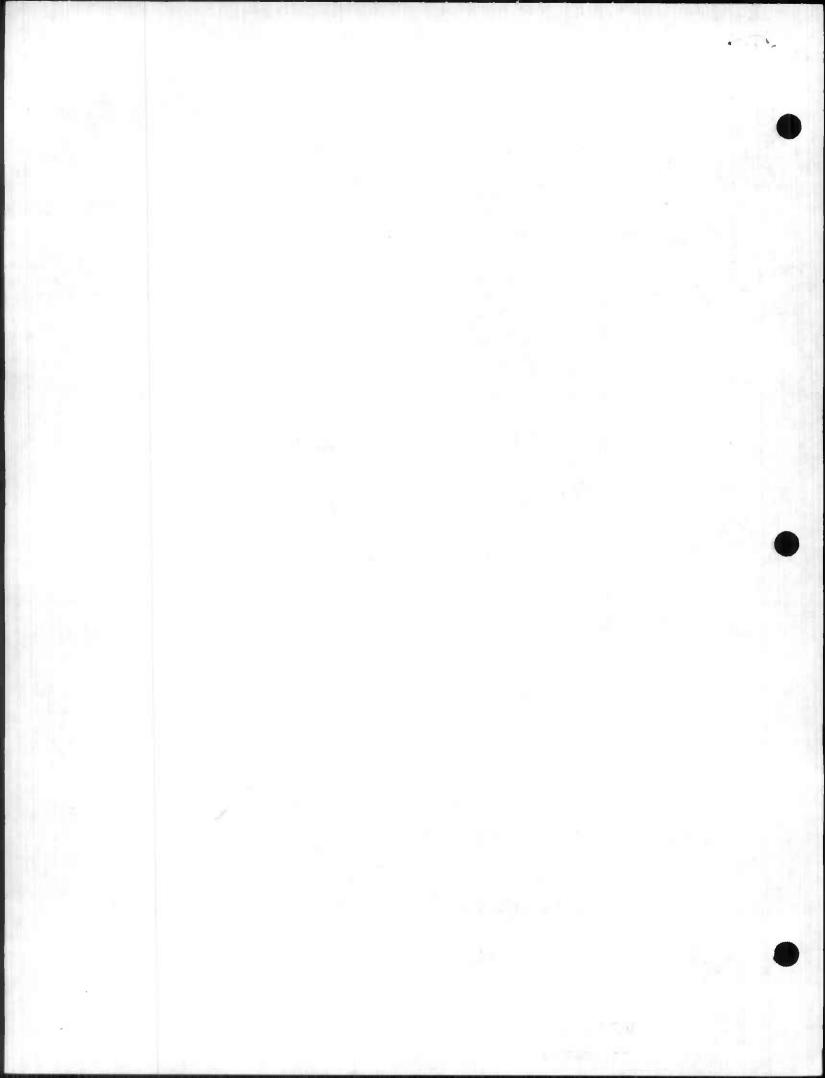
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State of Maryland / Department of Health and Mental Hygiene

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				Certifica	te of	Death		Reg. No.	00	C - 1 1 (
Dhualaia	1. Decedent's Name (First, Middle,							f Death Day	Year	3. Time of Death		
Physician /Medica	OCILII	F	obinson				JUL	Y 29,	2000	12:50 A.I		
Examine	4a Facility Name (If not institution,	The second second	7)				or Location of D	Peath 4c. C	ounty of Death			
154K	2814 KENNE 5. Social Security Number		ge (In yrs. last birt	hefaut If Unde	er 1 Year	BALTI		Righ	N/A	place (State or Foreign		
Funeral Director	225-38-3857	10M 20F		rs. Months			Ain. (Month	Day, Year) 04-42	Cou	ntry) VA		
2 .	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	and position						and Inside Chail Inside		
with the Maryland as or 28a-f show Lbe notified at	MD N	4	Balti	more						10d. Inside City Limits XI ☑ Yes 2 ☐ No		
th with th	10e. Street and Number 2814 Kennedy	Avenue			ip Code L218				on of What Cou USA	intry?		
020 020 urs a	11. Marital Status X Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 V If Yes, Give Year or Dates	?] No	13. Was Dec If Yes, sp 1 Yes	ecity Cubi	lispanic Origin' an, Mexican, Pi Specify:	? (Specify Yes o uerto Rican, etc.)	I. Raca - Ameri Black, White Specify:			
72 hours	15. Decedent's (Specify only highest Elementary/Secondery (0-12) 9th Grade 17. Father's Name (First, Middle, Li	Education grade completed)	16a.	Decedent's Us (Give kind of w	ual Occup	eation during most of d)	working	16b. Kind	d of Business/Ir	ndustry		
rithin ne.	Elementary/Secondery (0-12)	College (1-4o	5+1			-						
offied vert, in	9th Grade 17. Father's Name (First, Middle, Li	NA		ruck I	JEIV		Neme (First, Mic			g Company		
Maryland d2 should be file th and Mental Hy 7 is merked other traumate event	James	E. Robi	ngon			Milo						
S should and Me mark			19b.	Mailing Addres	ss (Street	and Number o	r Rural Route Ni	ımber, City or	atchet Town, State, Zi	^{ip Code)} 21218		
CENL		nson	2	228 N	Ca	lvert	Street	Ralt	imore	21218 Maryland		
Baltimore, Nemit. Pages 1 and Papariment of Heelth Important: If item 27 month, in the 27 m	20a. Method of Disposition		20b. Place of	Disposition (No. crematory or	ame of		Date	20c. Loca	ation - City or T	own, State		
Pages nent of int: If its	Burial 2 Cremation 3 4 Donation 5 Other (Spe		0 '				08-01	-2000	Dund	as, VA		
Baltimo pemit. Page Department o Important: If any injury or once.	21. Signature of Funeral Service Li									d 21202		
Depa Depa	> guszull	e curon		WM.C	. Ma	rch FH	1101	E. Nor	cth Av	enue		
Physician /Medical Examiner	23a. Part1. Enter the disease, or c shock, or heart failure. List of limited l								scular	Onset and Death Cliseine		
Box 68760, seath certificate be assented attending physician and dior use as the burial-transit	Ceuse (Diseese or injury that initiated events resulting in death) Last	c	Due to (or es a c									
death c	Port II Other desidence and disease		hand made and a little or too	Marine dead de-		one in March	025	Did tabassa u	as contribute	to the cause of death?		
P.O. hat the od by the detache		contributing to death	Dut not resulting in	the underlying	cause gn	/en in Part I.		1 Yes 2		/		
S 2 2 2							24a	Was an autops	v 24b. V	Vere autopsy findings		
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- F # d								1□ Yes 2	No 1	☐ Yes 2☐ No		
Of Vital Physicien: The this cartificate ral director, pag	25. Was cese referred to medical examiner?	Hospital:			Oth Oth	or:	Death (Check of		D			
this ald		28a. Date of fn	jury 28b. T		28c. Inju	4LI NUISII		ribe how injury		(h) SCENE		
Vision Attending r death. sctor: Afte by the fune	1 Natural 5 Pending 2 Accident investiga	(Month, E	ley Year) Ir	njury M		rk? Yes 2 ☐ No						
Division of standing P as a far death, at Director. After led in by the funer Contillation.	3 Suicide 6 Could no determin	ed 288. Place of I	njury - At home, far etc. (Specify)	m, street, facto	ory, office		28f. Locati City o	on (Street and r Town, State)	Number or Ru	ral Route Number,		
Hospi 14 hou Funer tely fill		Physician: To the host taminer: On the basis	of expriination and	death occurre Vor investigation	d at the tien, in my c	me, date and popinion, death of	lace, and due to	the ceuse(s) a ime, date and p	and manner as place, and due	stated. to the cause(s)		
To the To the comple		101	,	2	9c. Licens	e number		29d. Date	signed (Month	, Day, Year)		
1		41 h	6/ 0.C.M.E.					JULY 29, 2000				
F.w	30. Name and address of person w David Fowle		death (Item 23a) (Bal	timore.	Marvla	nd 2120	1			
State	21 Date filed (Month Day Year)		trar's Signature	24								
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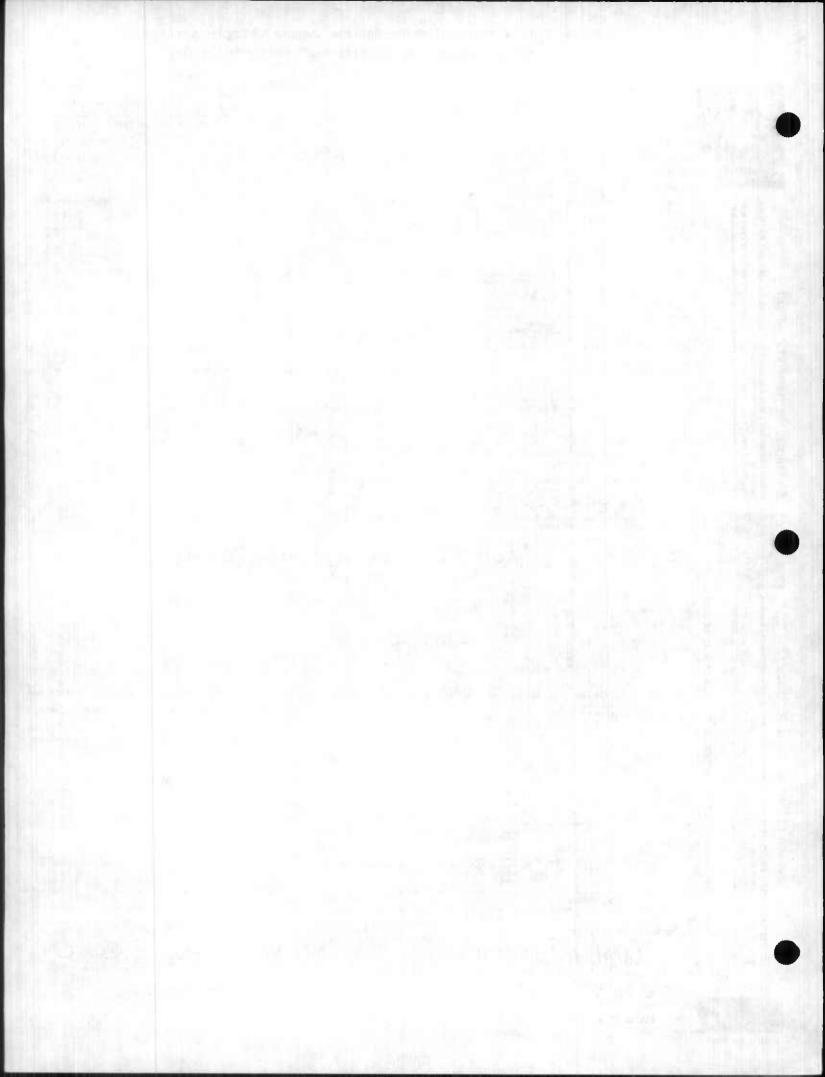
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate o	Death		Reg. No.						
	b		1. Decedent's Name (First, Middle, Las						2. Date of D Month	eeth Day	Year	3. Time of Death				
	Physicia /Medic		Catherine Do	lores	Ruppe	rt			Augus			12:30 a.m.				
	Examin		4a Facility Name (If not Institution, give	street and number	r)			4b. City, Tow	n, or Location of Dea	th 4c. County	of Death					
			5921 Daybreak T	err				Ros	sedale	В	altim	ore Co.				
-	Funeral		5. Sociel Security Number 6. Se		Age (In yrs. lest	birthday)	If Under 1 Yes	If Under 2	4 Hrs. 8. Date of B			ace (State or Foreign				
	Director		212-28-7284	□M 200 F	69	Yrs.	Months Dey	s Hours	Min. (Month, E	19,1931	Counti	laryland				
L			Usual Residence of Decedent						That off	13,1301		idi y i diid				
	Jan Man		10a. State 10b. County		10c. City, T	own or Loc	cation				10	d. Inside City Limits				
	Men.	ò	Maryland Baltimo	re Co	Ro	seda	16					1 ☐ Yes 2 No				
	ith the Marylar or 28a-f ahow	Directo	10e. Street and Number	0 001	1.0	Jour	10f. Zip Code			10g. Citizen of V	What Count	v?				
	with			~ - 1010				21206								
	after death with the Manyland or items 23s or 28s-! show miner must be notified at	Funeral	5921 Daybreak T		of Francis II C	12.11	Man Danadont e		in? (Specify Van or h		ed Sta					
		Š	11. Merital Status	12. Was Deceden Armed Forces 1 Yes 2 X	1 EVEL 11 0,5.	IS. V	Yes, specify Cu	ban, Mexicen,	in? (Specify Yes or N Puerto Rican, etc.)		ck, White, e					
20		by F	1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1	□ Yes 2 N	o Specify:		Specify	. Whi	to				
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5		Completed	15. Decedent's Ed (Specify only highest grad	de completed)	1	Give	lent's Usuel Occ kind of work dor DO NOT use reti	upation le during most d	of working	16b. Kind of Bu	usiness/indi	istry				
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2	Hygie ther t	8	12	2			Registe				1th C	are				
P	d off	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First, Middl		16)					
Vla	should be nd Mental nmarked o	2	George J. Rupper	t				Anna	a McGowar	McGowan						
Maryland	end end em		19a. Informent's Name/Relationship (7	ype, Print)	1	9b. Meilin	g Address (Stre	et end Number	or Rural Route Num	ber, City or Town,	State, Zip	Code)				
Σ	ges 1 and 2 should be filed within it of Health end Mental Hygiene. If from 27 is marked other than or other treumatic event, ins. M.		Mrs. Mary M. Reese	/ Sister		5921		k Terr	. Baltimo	re, Mary	land	21206				
re	of He item		20a. Method of Disposition			of Dispos	sition (Neme of natory or other p	lace)	Date	20c. Location -		n, State				
OF	ege ent o rt: H		## A Donation 5 Other (Specify) Moreland Mem. Park 8/8/2000 Baltimore, Maryland													
Baltimore	permit. Pege Depertment of Important: If eny injury or ence.	-														
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			Misse C	7.1.						Baltimor		21214				
ı,			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	ications that cause one cause on each	ed the deeth. I	o not ente	er the mode of d	ying, such as c	erdiac or respiratory	arrest,	1	Approximate Interval Between Onset and Death				
	Physician			1	1 1		1			5.0		Oriset and Death				
	/Medical Examiner		Immediate Ceuse (Finel disease or condition	. Met	astar	C	Lyna	Car	rcinor	na	>	mon				
П			resulting in death)		Due to (or as	a conseq	uence of):	2				Here of				
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68760,	eath certificete be executed attending physician end I for use as the burial-transit	edicai	that initiated events resulting in death) Last	c	Due to (or as	a consequ	uenca of):				1					
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XO	that tha death cer ed by the attendin detached for use	an/M		d												
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Records,	requiras een sign hould be									s an autopsy	24b. We	re autopsy findings				
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VItal	ysicien: The last continues of director, pege	Be	25. Was cese referred to medical examiner?						of Death (Check only	one)						
of		2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpai	tient 2 ER	/Outpatien	t 3 DOA	Other: 4 Nun	sing Home 5 Re	sidenca 6 Oth	er (Specify)				
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ō	Attending or death.	atic	2 Accident investigation					Yes 2 N	io							
Division	Atte octo by th		3 Suicide 6 Could not be determined	Zoe. Place of I	njury - At home etc. (Specify)	, farm, stre	eet, factory, offic	ю		(Street end Numb own, Stete)	ber or Rural	Route Number,				
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral	edicai	(Check only 2 Medical Exam	h occurred et the time	e, date and place,	and due to	the cause(s)									
	within 2 To the comple	M	29b. Signature end title of certifier		29d. Date signe	ed (Month, L	Dey, Year)									
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	3		20 Name and office of the	Wall of M	dooth (the co	le) (Terra	Drint)	9133	14	I look,	١١٥					
	m./		30. Name and address of person who d	completed cause of	lech D	(Type, I	1/31 /	Rolli	more, our	21239						
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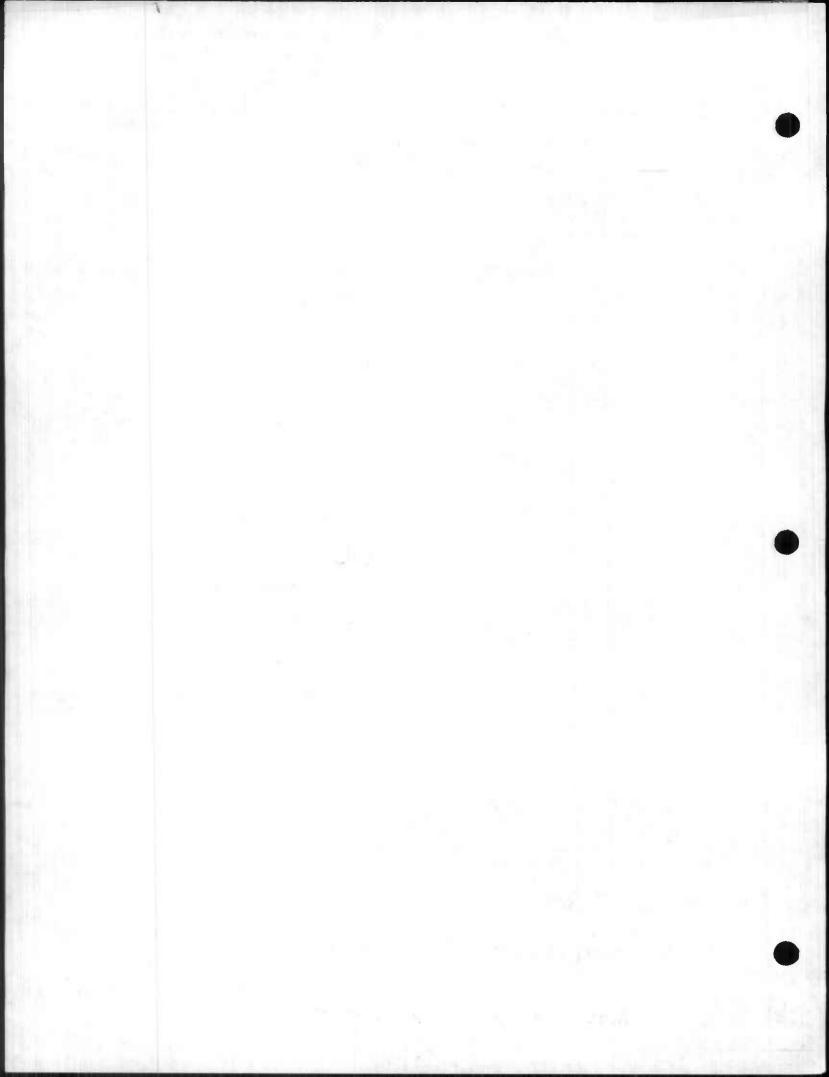


State of Maryland / Department of Health and Mental Hygiene 24778 Certificate of Death AMENDED ITEM #5 PER FH G786 8/7/00 AH 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 9:26AM JAN KOSEN 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner of BATIMORE SINAT HOSPITAL BOLTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. MAR. 9, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 10M 20 F 30-6581 86 Yrs. POLAND **Director** Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 PHILIPS DRIVE 21208 238 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: py WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 PAINTER CONTRACTOR CONSTRUCTION 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be nent of Health and Mental ant: If Hem 27 is marked o JACOB ROSEN PATRICIA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) I and 2 important of Health as any injury or other 0058. BLUMA ROSEN / WIFE 3503 PHILIPS DRIVE - BALTIMORE, MD 21208 20b. Placa of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cametery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 8/4/00 RANDALLSTOWN, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. Toler 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical COR PULMONALS **Examiner** Due to (or as a consequence of) PULMONARY (Due to (or as e consequenca of) Physician/Medical Examiner TYPERTENSION The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, CONOESTIVE HEART Due to (or as e consequence of): use as the BILBEND Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, P funeral director, page 2 should be 24b. Were eutopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy performed? this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred Division 1 Matural 5 Pending investigation after death. 2 No 1 Yes 2 Accident the 6 Could not be determined 3 Suicide Placa of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) completely filled in by 4 Homicide within 24 hours a To the Funeral C Fo the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 20b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and add person who completed cause of death (Item 23a) (Type, Print) Pikesville, KOAD Green ree 18 38 31. Date filed (Month, Dey, Year) AUG 0 7 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death August 5, Dex 2000 **Physician** William Reid Smith, Sr. 1:25 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health at North Arundel Glen Burnie Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1918 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Deys Hours Months Min. 218-09-1412 1 M 2 □ F 81 Maryland Yrs. Director **Usual Residence of Decedent** Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health end Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23s or 1423 Virginia Ave. 21144 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in \$5.0 -1 ☐ Never Merried 2 ☑ Married 1. Yes 2 No fryes, Give Specify: White 1946 21215-0020 1 ☐ Yes Ž No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Walter Lee Smith Gertrude Alice Batton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 6 William Reid Smith, Jr. /Son 1423 Virginia Ave. Severn, MD 21144 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State Aug. 8, 1 Burial 2 □ Cremation 3 □ Removel from State Dulaney Valley Mem. Gar. 4 ☐ Donafion 5 ☐ Other (Specify) 2000 Timonium, MD 21. Signatura of Funeral Service Licensee 22. Neme and Address of Fecility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.F. Glen Burnie, MD 21061

kins that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate F.A.

Approximate F.A. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition rasulting in death) **Examiner** Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in death) Last Preumonia P.O. Box 68760. Due to (or es a consequence of): mphypema Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings evailable prior to Completed 24a. Wes en autopsy performed? Recent Non Qware Myocardial Infanction completion of cause of death? ranoxypmal Atrial 1 Yes 2 No certificate 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28e. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending invastigation 1 XNatural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 24 hours XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier edical within 24 ho To the Fune completely f \$ 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) lam M.D August 7, 2000 30 Neme and eddress of person who completed causa of deeth (Item 23a) (Type, Print) 1600 CRAINHUY, SUITE POI GLEN BURNIE, MD 21061

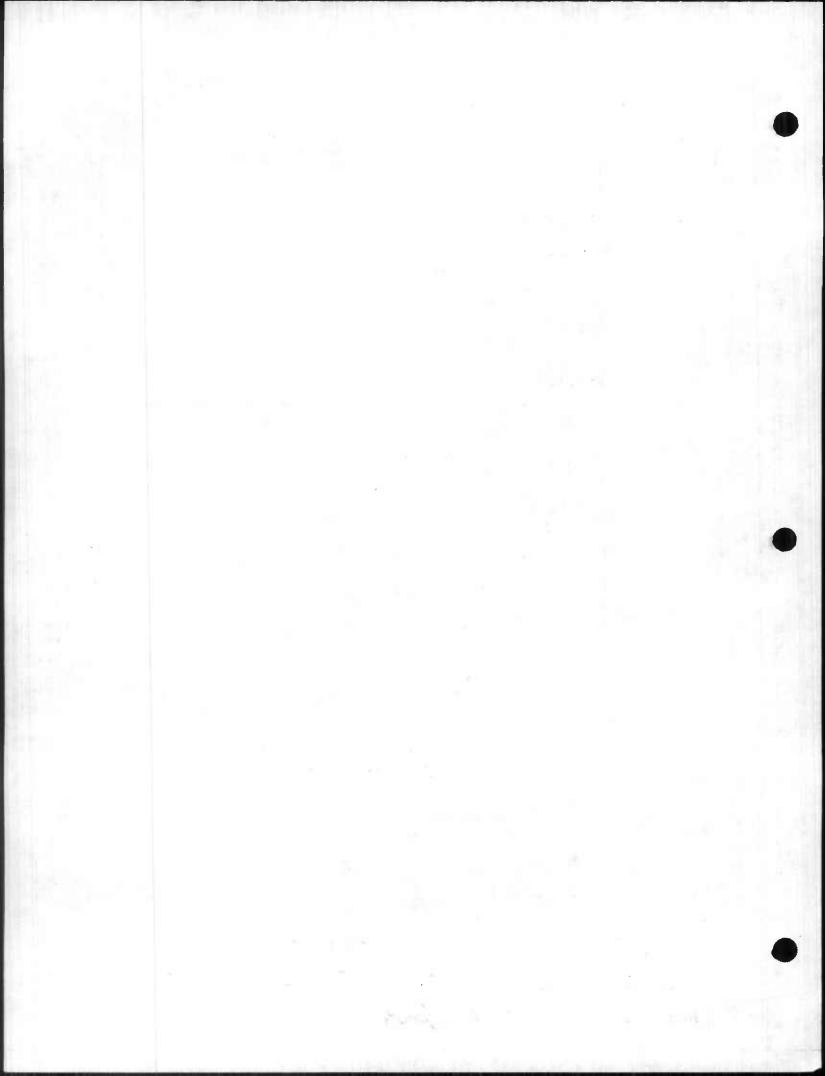
DHMH 16 Rsv 6/95

Registrar

Jukhhal Jam, 31. Dete filed (Month, Day, Year)

AUG 0 7 2000

32. Registrer's Signeture



Shade, William, SR

Please Type or Print in	Black Ind	elible Ink	. Assu	re A	II Copies A	Are Legi	ble.	
State of Maryl		tment of lificate of				iene og. No.	00	24780
WILLIAM SHA	ADE :	SENIOR			2. Date of Deeth Month AUGUST	Day	Year	3. Time of Death 5: 30 Am
(If not institution, give street and number) LIZABETH REHATS	1 NURS	ING	4b. City. To Balti		ocation of Death	4c. County N/A		
		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth	Year 920		place (State or Foreign YYand
of Decedent								
d Anne Arundel	City, Town or Local							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ipley Ave.		10f. Zip Code 2106		h	10	og. Chizen of United		
Illed Z Mailled 183 165 Z 110	1942-	as Decedent of Yes, specify Cul	oan, Mexicer	gin? (Sr n, Puerto	pecify Yes or No- Rican, etc.)		ck, White,	cen Indian, etc. ite
15. Decedent's Education ecify only highest grade completed)	16a. Deceder (Give ki	nt's Usual Occu nd of work done O NOT use retin	pation during mos	t of worl	king	16b. Kind of B	usiness/In	dustry
condary (0-12) Collega (1-4or 5+)		Manage			1917	Aut	omot	ive

18. Mother's Name (First, Middle, Maiden Sumame)

Jenny Tyson

Dete

421 Crain Hwy. S.E. Glen Burnie, MD 21061

DECUBITI

DISEASE

24a. Was an autopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only ona)

1 Yes 2 No

28d. Describe how injury occurred

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda)

10 Lennon Ct. Glen Burnie, MD 21061

Aug. 5, 2000

Kirkley-Ruddick Funeral Home P.A.

20b. Place of Disposition (Name of cemetary, cramatory or other place)
Metro Crematory

SEPSIS

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

Due to (or as a consequance of)

MULTIPLE INFECTED

Due to (or as e consequence of):

PERIPHERAL VASCULAR

22. Name and Address of Facility

One that did used the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrast

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified as 3altimore, Maryland 21215-0020 **Physician** /Medical Examiner

Physician/Medical by Completed Be

Examiner edical Certification: To

23a. Part1. Enter the disease, or complicity shock, or heart failure. List only or 27. Manner of Death 1 ANatural 2 Accident 3 Suicide

1. Decedent's Na

4e Fecility Neme

ST. S 5. Social Security

219-01-

Usual Residence

Marylan

10e. Street and h 313 Sh

11. Merital Status 1 Never Ma

3 Widowed

(Sp Elamentary/Se 9

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

John Shade 19a. Informant's Name/Relationship (Type, Print)

4 Donaffen 5 Othar (Specify)

William H. Shade, Jr. / Son

1 ☐ Burlal ZGCremation 3 ☐ Removal from State

10e. Stete

Director

Funeral

þ

Completed

Be

Physician √Medical

Examiner

Funeral

Director

signed by the attending physician and the detached for use as the burial-transit Division of Vital Records, P.O. Box 68760. After this To the Hospitat or Attending I within 24 hours after death.
To the Funeral Director: After

Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. URINARY TRACT INFECTION CEREBROVASCULAR 25. Was cese referred to medical examiner? 1 Yes 2 No 5 Pending investigation

4 Homicide

29a. Cartifier (Check only one)

6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Vasanthalcumarmo

28a. Date of Injury (Month, Day Year)

29c. License number D42510

28c. Injury at Work?

1 Yes 2 No

29d. Dete signed (Month, Day, Year) AUGUST, 5, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Did tobacco usa contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown

20c. Location - City or Town, Stete

Approximate Interval Between Onset and Death

MONTHS

YEARS

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 2 No

DAYS

Catonsville, MD

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

M.VASANTHA KUMAN, 821: N. EUTAWST, SUITE 407, MD 21201

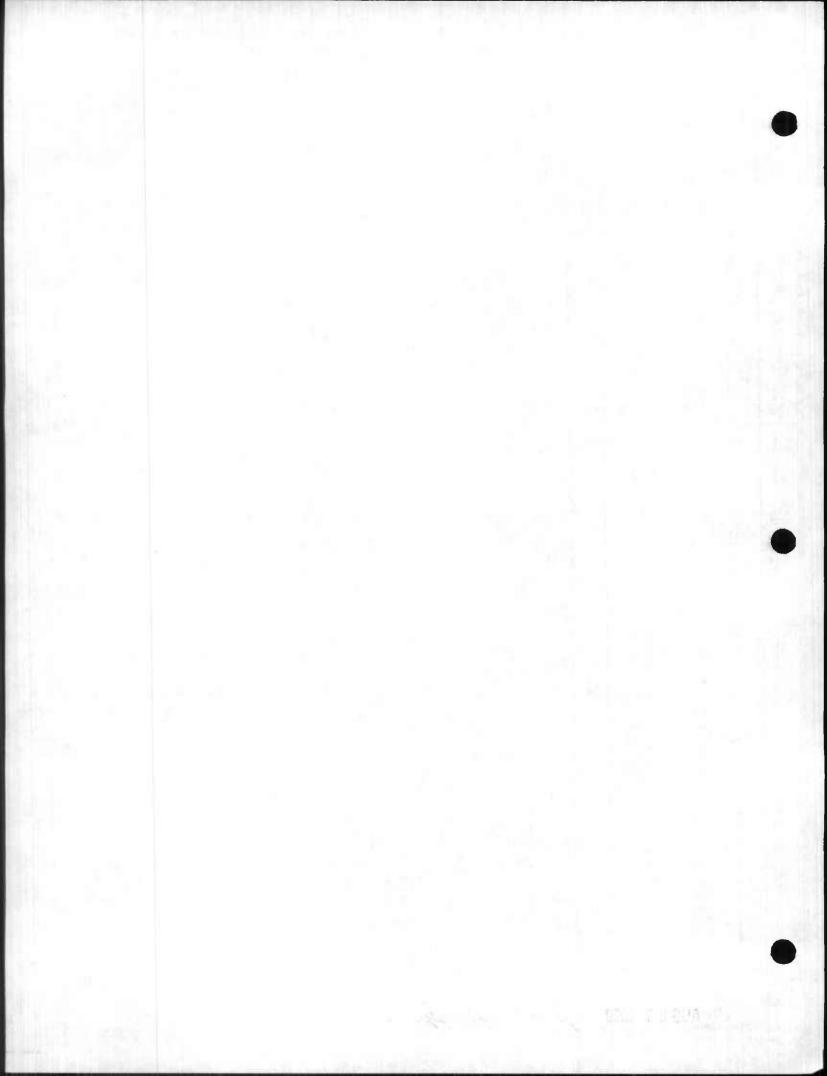
31. Date filed (Month, Day, Year) UG 0 7 2000

Registrar DHMH 16 Rev 6/95

State

32. Registrer's Signature

ORIGINAL



C1.11							3	
Brenda	J. Smith AMEND ITEMS:	#23	PART I,	State of Maryland / 27, 28A-F PER MEX	Department of Health and I Certificate of Death	Mental Hygiene	00	2478

	1. Decedent's Nema (First, Middle, L	ast)	Death		Reg. No. Dete of Deeth Month Day Yeer 3. Time of Death							
Physician /Medical	BRENDA J. SMIT	CH					July		2000	9:57	A.M	
Examiner	4a Facility Name (If not institution, g	ive street end number)				4b. City, Town	, or Location of D	eeth 4c. Cou	nty of Deeth			
4	15 South Linwoo						imore		N/A			
Funeral Director	unk	Sex 1 M 2 M F	e (In yrs. lest bii 49	Yrs. If Und Month	ar 1 Yaar s Deys		Min. (Month,	Birth Dey, Year) 7, 1951	9. Birthp Cour	place (Stete or ntry) MI		
1-	Usuet Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location					1	0d. Inside City	y Limits	
a or 28a-f show the northed at	MD N/A	5 B 8		altimore	2		- Files			1X Yes		
r Here 23a or 28a-fe note must be promise Funeral Director	10e. Street and Number 15 S. Linwood S	treet		10f. 2	ip Code	21224		10g. Citizen o	f Whet Cour			
by by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 🖾 Divorced	12. Wes Decedant Armed Forcas? 1 Yes 2 1 If Yes, Give Yeer or Detes:	Ever in U,S.		edent of I ecify Cub 2X No	lispenic Origin an, Mexican, F Specify:	? (Specify Yas or puarto Rican, atc.)	No- 14. F	ace - Amaric leck, Whita,	an Indian,		
2 H 4	15. Decedent's I (Specify only highest g		16e	Decedent's Us (Give kind of v life. DO NOT	val Occup	during most of	working	16b. Kind of	Business/Inc	dustry		
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and Mental Hygie america other t umetic event, the To Be Co	17. Father's Neme (First, Middle, Las	(1)					Neme (First, Mic	idle, Maiden Sum				
Mental or artic eve	Willie Ford					Rub	y Baird					
em ei	19e. Informent's Neme/Reletionship	(Type, Print)	198	. Mailing Addre	ss (Street	and Number	or Rurel Route Nu	mber, City or Tov	n, Stete, Zip	Code)		
	O.C.M.E.					Street	Baltimo	Baltimore, MD 21201 Dete 20c. Location - City or Town, State				
0	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special Contents)	□Removel from Stete	20b. Plece o cemeta	f Disposition (N ry, cremetory or	eme of othar ple	ce)	Dete	20c. Locatio	n - City or To	own, State		
Department important: If eny Injury or price.	21. Signature of Funeral Service Lice Ronal d	Wade, Dir	oard 65. 21201	5 W. Bal	timore	Stree	t					
nysician Medical xaminer	shock, or heert feilure. List onl Immediate Cause (Final disease or condition resulting in death)	e		OTIC IN		CATION				Intarval Betw Onset and D	eath	
physiclen and s the burial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	£				11-17						
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gned by the attending be detached for use of by Physician/M	Pert II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying	ceuse gi	ven in Pert I.		Old tobacco use			Unknov	
been s should leted							24a. V	Ves an eutopsy enformed?	av	ere eutopsy fir eilable prior to impletion of ca death?	0	
certificate hes irector, pege 2.							(Yes 2 No	1 [∃Yes 2□I	No	
is certifica director, To Be (25. Wes case referred to medical examiner?					26. Piece of	Deeth (Check or	nly one)				
00	1 Yes 2 No	Hospitel: 1 Inpatie		utpatient 3 1	JUA			Residence 6		y) at so	cene	
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within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	2 Accident investigeti 3 Suicide 6 X Could not 4 Homicide determine	/-14-U	ury - At , Te	TESIDE	ory, office	Yes 2000	281. Location	on (Street and Nu Town, Stete)	mber of Rure 5 S.	J Boute Numb	ber. D A	
n 24 hours in Pletely filled edical Ce		Thysician: To the best orniner: On the basis of end menner sta	examination en				pleca, end due to	the cause(s) end	menner es s)	
within 2 To the comple	29b. Signature and title of certifies	Sing meniner Sta	sa number				Dey, Year)					
s ⊨ ŏ	1 Mounte		July 15, 2000									
	30. Name end address of person who	completed cause of d	eeth (Item 23a)	(Type, Print)		7	altimore					

AUG U 7 ZUUU

19 mm

Shirley Thomas Stephenson Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Mandard / December 1

State of Maryla

and /	Dep	artme	ent	of	H	leal	th	and	Mental	Hygiene
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ent of Health and Men	tal Hygiene	00	01	***7	0	^
ate of Death	Reg. No.	00	64	1	d	2

					001	unouto c	of Death		R	eg. No.		Long	
	1. Decedent's Nam	a (First, Middle, La	isf)					2	. Date of Dee	th Dev	Yeer	3. Tim	e of Death
sician edical	SHIRLEY	THOMAS	STEPHENSO	ON					July		2000	07:	43 A.M.
miner	4a Facility Name (If not institution, giv	e street and numb	oer)			4b. City, To	wn, or Loca	tion of Death	4c. County	of Death		
		6017	Crown St	reet			Seat	Plea	sant	Princ	ce Ge	orge	's
ral	5. Sociel Security N			Age (In yrs.	lest birthday)	If Under 1 Y	aar If Under	24 Hrs. 8	Date of Birth (Month, Dey,	Year)	9. Birthp	ileca (Ste	ete or Foreign
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	Usual Residence of	1		10- 00	. Town sale						14	Od Incid	- Oh - I looks
-	10a. State	10b. County	Canada	TOC. CIT	y, Town or Lo		cont				1		e City Limits
cto	MD	Prince	Georges		269	at Plea	Sant						Tes ZALINO
Director	10e. Street and Nu	mber				10f. Zip Coo	ie		1	0g. Citizen of \	Whet Coun	itry?	
Funeral [6017 Cro	own Stree	t				2074	43		US	SA		
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F	1 Never Marr	ied 2 Married	1 ☐ Yas 2 If Yes, Giva			☐Yes 2☒				Specify			
) D	3 Widowed	4 Divorced	Yaar or Dete	es: un						- Cpoon,		vhite	2
etec	(Spec	15. Decedent's E	ducation ade completed)		16e. Deced	lent's Usuel Ockind of work do	ccupation ona during mos	t of working		16b. Kind of B	usiness/Ind	dustry	
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	O.C.M.E	•			111	Penn S	treet	Balti	more, l	MD 212	01		
	20e. Method of Dis		Jp		Pleca of Dispo ametery, cren	sition (Neme onetory or other	plece)	1	Dete	20c. Location -	- City or To	wn, Stet	0
		☐ Cremation 3 ☐ 5 🖾 Other (Special		919									
	21. Signeture				22	Name end Ad	ddress of Fecilit	ty.	(55.1	I D-1-			
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	thock, or hea	the disees, or com art failure. List only	one cause on eac	h line.								Intervel	Between and Death
	Immediate Cause	(Finel	G.	H	1 -						1		
	disease or condition		· Fa	My	hic	ier							
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00-4337-005 GEORGE STAMOULES

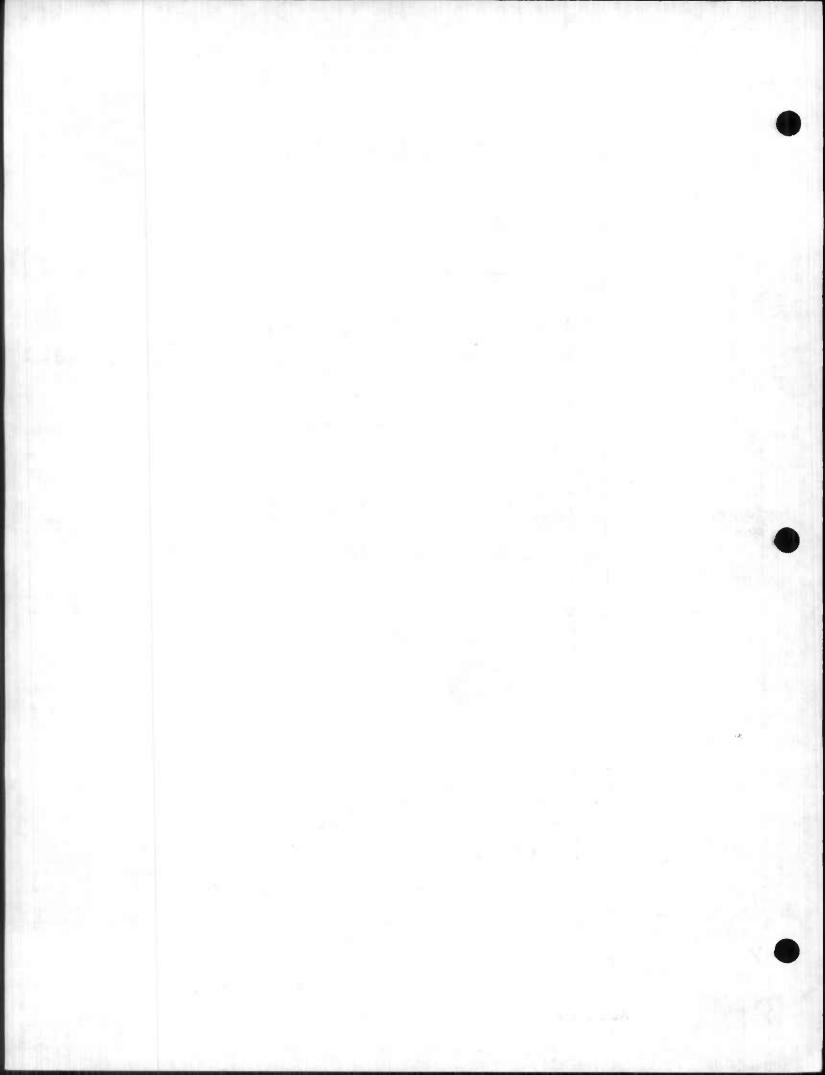
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

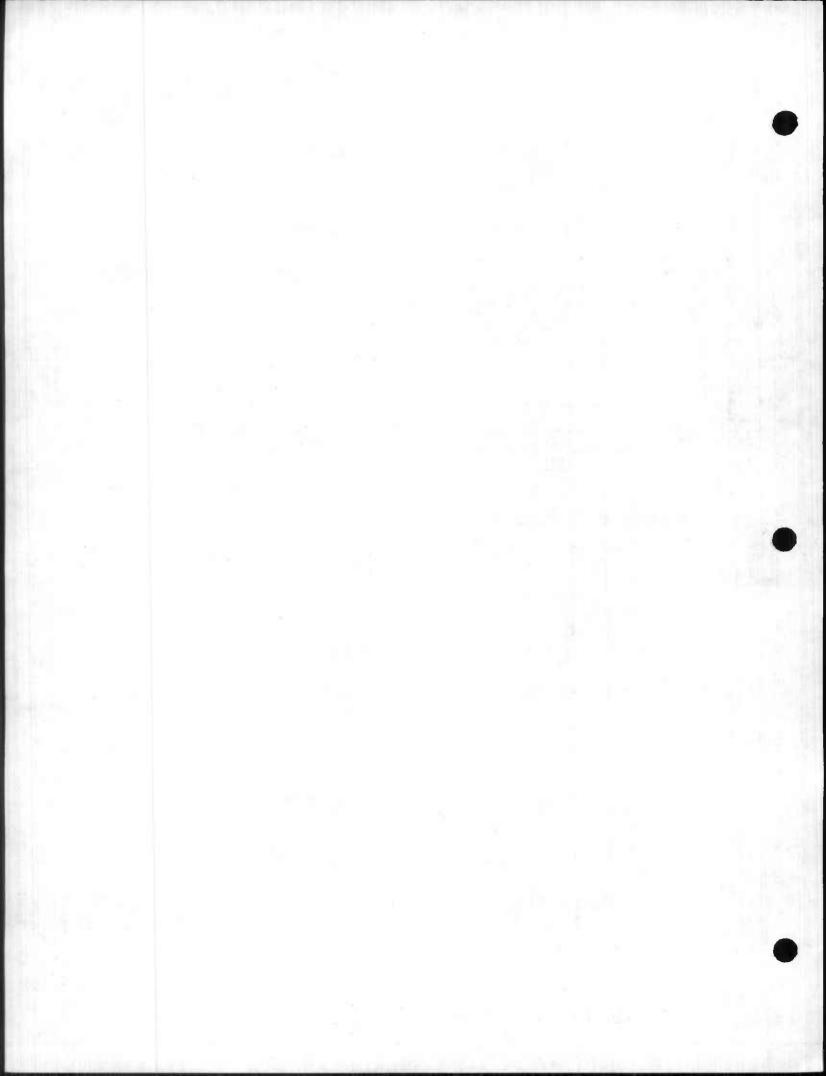
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	Physician	Coore	o T Ctom	201123						Month	Day	raeY	05 55 3 34	
	/Medical		e T. Stan						th Ch. Town or	AUGUS'		_2000	05:55 A.M	
1	Examiner	4e Facility Name	(II not institution, gi	ve street end number)					4b. City, Town, or		4c. C	ounty of Deal	h	
		6698	3 Securit	y Boulevar	d				Woodlawn		E	BALTIM	ORE	
	Funeral	5. Social Security I			e (In yrs. lest b	irthdey)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.		th Year)	9. Birt	hplace (Stete or Foreign	
	Director	287-44-8	193	1⊈M 2□F	52	Yrs.	MONITIS	Days	Hours Min.	Nov. 6		_	hington DC	
_		Usual Residence			72				1	1100	, 1/7	/NGS	umgcon iv.	
	E S	10a. State	10b. County		10c. City, Tox	wn or Loca	ation						10d. Inside City Limits	
	fary of	MD	NT / A		D-14								No Yes 2 No	
	he he he	TID	N/A		Balta	Imore	1	0.1.			10- 0**		Λ	
	with the Ma s or 28s-f a be notified	10a. Street and Nu	umber			10f. Zip Code					Tug. Citize	n of Whet Co	ountry?	
	15 v 15 v 15 v 15 v 15 v 15 v 15 v 15 v	552 S.		21223					U.S.					
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0	\$ 4 E	1 Never Mar	ried 2 Married	Armed Forces						o i noan, oro.,		Black, Whit		
5-0020	within 72 hours after death with the Maryland ena. than "natural", or items 23s or 28s-f show he Medical Examiner must be notified at homistad by Figures i Director	3 ☐ Widowed	4 Divorced	If Yes, Give Year or Dates:		11	☐ Yes 2	X NO	Specify:		S	pecify: Wh	ite	
Ō	led within 72 ho tygiene. ner than "naturn nt, the Medical Commisted		15. Decedent's E	ducation	168	a. Decede	nt's Usua	I Occu	pation		16b. Kind	of Business	Industry	
2	Tale tale	(Spe	cify only highest gr	ade completed)		(Give ki	ind of wor O NOT us	rk done	during most of wo	rking				
2121	with the same	Elementery/Sec	ondery (0-12)	College (1-4or	5+)						Tne	urance		
64	Hygie ther if	47. Ferbada Maria	Wind Address Lon	3	100	PO	rter		I d.D. Mathada Mar	no (Fine Asidella				
č	tal Hygied other overt, to		(First, Middle, Las	,					18. Mother's Nar	me (First, Middle,	, Meiden St	imeme)		
10	marked metic	Thomas	s Stamoul	es					Gera	aldine M	artin			
Maryland	2 sho and I		lame/Reletionship	(Type, Print)	19	b. Mailing	Address	(Stree	t end Number or Ru	urel Route Numb	er, City or 7	own, Stete,	Zip Code)	
	end 2 eaith a n 27 is	Suo D R	ass / Fri	and		552 S	outh	Ro	ntalou St	- Roltin	mara	MD 2	1222	
altimore,	He He	20a. Method of Dis		ena	20b. Place	of Disposi	ition (Nen	ne of	ntalou St	Date	20c. Loca	tion - City or	Town, State	
٥	Pages nent of int: If its iry or or	1 Burial 2	Cremation 3	Removal from State	cemer	ery, creme	erory or or	rner pie	ice)					
	ment ment: lury o	4 Donation	5 Other (Speci	fy)	Metr	ro Cr	emat	ory	, Inc.	8/7/00	Balt:	imore,	Maryland	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 23s-1 show any Injury or other treumatic event, the Medical Examination and any least. To Re Completed by Funeral Director		uneral Servica Lica			22.	Name and	d Addr	Society	Of Mom	10-1	T		
8	88558	Thom	as Gregor	- July									0.0	
				plications that cause	d the death. Do	not enter	the mod	ege e of dv	rick Road	c or respiratory a	ore, I	Md.212	Approximate	
		shock, or he	art failure. List only	one cause on each I	ine.						77		fnterval Between Onset and Death	
A	Physician /Medical	Imma diata Causa	/Final	7,	~ ·	/		1 .						
9	Examiner	Immediate Cause disease or conditi	on	Intra -	Oral 0	Gun	shot	1000	end					
		resulting in deeth)			Due to (or as a							W/ 15		
щ	7 5 6													
	d ansign	Sequentially list of	anditions C	b	Due to (or as e	consequ	consequence of):							
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68760,	o certificate be assected and and physicien and use as the bural-transit	Cause (Disease o	r Ińjurý	c										
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ox e	ling ling as as			d								25		
Bo	ten or us													
	law requires that the death as been signed by the atter to should be detached for	Part fl. Other signi	ut not resulting	in the und	derlying ca	ause gi	iven in Part I.	23b. Did	23b. Did tobacco uss contribute to the cause of death?					
P.0	t the									10	Yss 2	robably 4 Unknown		
	as tha													
9	d by d									24a, Was	an eutops	, 24b.	Were eutopsy findings	
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	The late has page										Yes 2	No	1 Yes 2 No	
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Division	end eath or: /	2 Accident	investigation	12 - 3-00		25 A	- IVI	1	Yes 2 No	2017-11	T// C TRO	1		
>	er der	3 Suicide 4 ☐ Homicide	dotorminos	200. Placa of In	jury - At home, I c. (Specify)	1 -				28f. Location (City or To		Number of R	curity Bl vel	
ō	tal or Attending P rs after death. al Director: After t led in by the funers Certification:					bui	Reling	,		Bulha	inc	Mel	carry Diver	
	all y fills			hysician: To the best										
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	(Check only one)	2 Medical Exa	miner: On the basis o and manner st	f examinetion a ated.	nd/or inve	stigation,	in my	opinion, deeth occi	urred et the time,	dete end p	iace, end du	e to the ceuse(s)	
	Me Me	29b. Signature en	d title of certifier				290	. Licen	se number		29d. Date	signed (Mon	th, Dey, Year)	
	8 4 8 4		10.	1/91/					C.M.E.			JST 03		
	Y		Mennin	1 Checken				0.0	> 1 T - L' -	<u> </u>	AUGU	131 03	, 2000	
	17-611	30. Name end add	ress of person who	completed cause of	death (Item 23a)) (Type, P	rint)							
	m	Ven	nts CI	hutero	111 P	enn s	Stree	et.	Baltimor	e, Marv	land 2	21201		
	State	31. Date filed (Moi	nth, Dey, Year)		er's Signature	44		/						
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Dec :			Certificate of			eg. No.	0 21.781
Physician	Decedent's Name (First, Middle, Last)				2. Dete of Death Month		3. Time of Death
/Medical	Robert P. Slaby				Aug. 4	, 2000	3:40 AM
Examiner	4e Facility Name (If not institution, give street a	and number)		4b. City, Town, or Lo	f Deeth		
144	Anne Arundel Medic	al Center		Annapolis	S	Anne	Arundel
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Yeer Months Days		8. Dete of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Director	578-40-2983 1XPM 2	DF 69	Yrs.	110010	Mar. 9,	1931	Kentucky
9	Usuel Residence of Decedent	The second					
the the	10a. Stete 10b. County	10c. City, To	own or Location				10d. Inside City Limits
vith the Ma tor 288-f a be notified	MD Anne Arunde	1 Cr	cofton				1 ☐ Yes ※☐ No
or 23	10e. Street and Number		10f. Zip Code	10	g. Citizen of Wi	nat Country?	
	1497 Crofton Parkwa	v	2111	4		USA	
filer death v filere 23s siner.must	11. Merital Status 12. We	s Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cut		cify Yes or No-	14. Race	- American Indian,
Pur plant		ned Forces? Yes 2 No es, Give / 0 / 50			Hican, etc.)	Black	, White, etc.
02 02 02	3 ☐ Widowed 4 ☐ Divorced Yes	es, Give er or Detes: 49/52	1 ☐ Yes 2]() No	Specify:		Specify:	White
21215-0020 d within 72 hours at giene. the Medical Exam completed by F	15. Decedent's Education	10	6a. Decedent's Usual Occu	pation	1	16b. Kind of Bus	iness/Industry
I 21215-0 led within 72 to typiene, wr then "natur it, the Medical. Completed	(Specify only highest grade comp	llege (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of worki ed)	ng		
212 Distriction of the state of		5+	Attorney			Self E	mployed
ind tel thy dothe event.	17. Fether's Neme (First, Middle, Last)		TICCOTTICY	18. Mother's Neme	(First, Middle, N		
Maryland d 2 should be file th and Mental Hy 7 is marked othe treamatic event	George D. Slaby			Barbar	ra Peebl	OC.	
VI SAN P	19a. Informent's Name/Relationship (Type, Pri	n <i>t</i>) 1	9b. Mailing Address (Stree				itate. Zip Code)
M dd dd dd dd dd dd dd dd dd dd dd dd dd		1	497 Crofton				
o - Had	Louise A. Slaby / Wif		of Disposition (Name of Mery, crematory or other pla				ity or Town, State
Saltimore emit. Pages 1. Appartment of Hs mportant: If Hen ny Injury or oth nos.	1 Burial 2 Cremetion 3 Remove	from Stete ceme	etery, crematory or other pla				in your round old to
the grant of	4 □ Donetion 15 □ Other (Specify)	Metr	o Crematory,		3/5/00	Baltin	nore, Maryland
Ball Separation of the separation of the separat	21. Signature of Funeral Service Licensee		22. Name end Addr Cremation	ess of Fecility	Maryla	nd Inc	
m 202 6 9	Thomas Gregor		299 Freder	ick Road I	Raltimor	a Ma '	21229
	23a. Part1. Enter the diseese, or complications shock, or heart failure. List only one caus	that caused the deeth. D	o not enter the mode of dy	ing, such es cardiac d	r respiretory erre	est,	Approximete Interval Between
Physician	shoot, or heart failure. List only one caus	e on each time.					Onset end Death
/Medical	Immediate Cause (Finel	1 10 -	a do	11:0	- > 0		
Examiner	diseese or condition resulting in death) a.	-0100017	KI SELY	61132	+ 3/9		10 7347.
	7	Due to (er es	a consequence or):	/	11		1
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cate be axecuted physicien and the burial-transit calcal Examirations and calc	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c	Due to (or es	e consequence of):		,		1
be be be be be be be be be be be be be b	Cause (Disease or Injury thet initiated events						
(0 = 0	resulting in deeth) Last	Due to (or es	e consequence of):				
	d						
O the pro							1
- p a g	Part II. Other significant conditions contributing	g to death but not resulting	g In the underlying cause gi	iven in Pert I.	23b. Did to	ribute to the cause of death?	
P.O. thet the ed by th detach.					1 🗆 Ye	8 2□ No	3 Probably Onknown
bed by							
cords v requires been sign should be					24a. Was er perform		24b. Were autopsy findings available prior to
Records, na law requires t s has been signe ga 2 should be					ponom		completion of cause of deeth?
					1□ Ye	s 2 No	1 □ Yes 25 No
Vital I	25. Wes case referred to medical			oe Black I Down			1 L 145 2 2 140
	exeminer?	1 Diagram	Outputings and not lost	26. Place of Deeth			(C24.)
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Division of the dead of the function of the fu		Dete of Injury (Month, Day Year) 28t	Injury Wo	rk?]Yes 2 □ No	10		
Division or Attending after deeth. Director: After d in by the fune	2 Accident Investigation 3 Suicide 6 Could not be	Olege of trive			206 Loopties (C)	root and the	e os Dural Devite Alvert
or At after of the point of the	4 Homicide determined 28e.	building, etc. (Specify)	, farm, street, fectory, office		City or Town		r or Rural Route Number,
The Hospital of 24 hours in 24	(Check only 2 Medical Examiner: On	the basis of examinetion	lge, death occurred et the ti end/or investigetion, in my	ime, date end place, opinion, death occurre	end due to the ca ed et the time, da	iuse(s) end men ite end place, ar	ner es stated. nd due to the cause(s)
To the P within 2 to the Complet	one) en	d menner steted.					
To the Com	29b. Signeture and title of certifier		29c. Licen	se number	29	d. Date signed	(Month, Day, Year)
17/	1/10		DI	4403		8/41	100
11	30. Name and address of person who complete	d cause of death (Item 23e	e) (Type, Print)			51.6	116
m o	Andra Debin	40	was milzh	11-11.	Re-1	1300	116
State	31. Date filed (Month, Day, Year)	32. Registrer's Signeture					
Registrar	8/ AUG 0 7 2000	Geneva	D Soon	6			
			1	-			



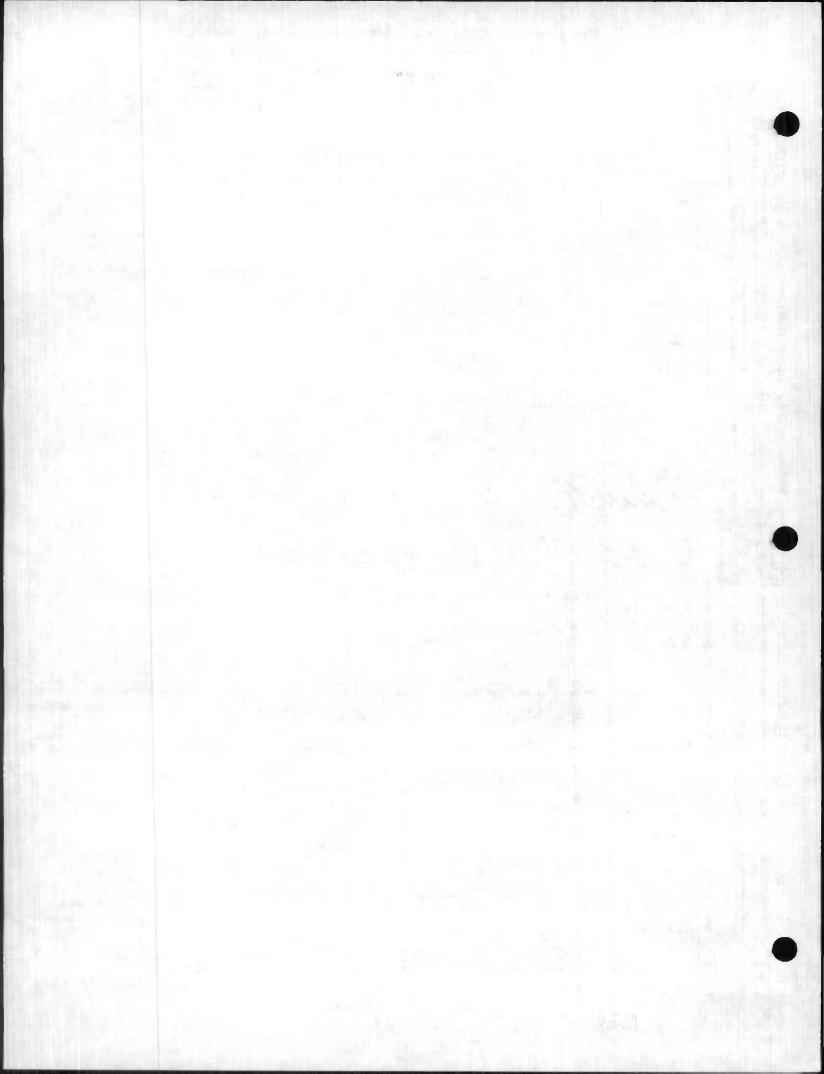
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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						00	inicate of	Dodin		Reg. No.				
	Physician	1. Decedent's Nar SHIRLEY		Last)	SCHN	NEIDER			2. Date of D		000	3. Time of Death 11:45AM		
9	/Medical Examiner	State of Section 1		give street and num				4b. City, Town, BALTIM	or Location of Dee		y of Death	Œ		
	Funeral Director	5. Social Security 218–40–04		. Sex 1□ M 2√ F	7. Age (In yrs.	lest birthdey) 95 Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of B (Month, L JAN . 5	irth Day, Year)	9. Birthp	place (State or Foreign htry) RUSSIA		
ь	p	Usuet Residence	of Decedent		10c. C	ity, Town or Lo	cation				1	Od. Inside City Limits		
	or 28a-f sho be notified at Director	MD N/A BALTIMORE										1 ¥ Yes 2 □ No		
	or 28s-t s be notified	10e. Street and Nu					10f. Zip Code			10g. Citizen of	ntry?			
	4 52 m	3906	FORDS LA	NE #C				21215		U.S.				
020	r, or here camber in		rried 2 Married	Armed For	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 № No 1 □ Yes 2 № No 1 □ Yes 2 № No				? (Specify Yes or Puerto Rican, etc.)	lo- Bia Specil	ck, White,	etc. WHITE		
2-0	Seal E	/Cne	15. Decedent's ecity only highest	Education		16a. Dece	dent's Usual Occi	upation	warking	16b. Kind of B	lusiness/in	dustry		
21215-0020	ed within 72 ho ygiene. er then 'neturn t. the Medical.	Elementary/Sec		College (1-	4or 5+)	L. Calca	kind of work don DO NOT use retir	ed)	Nording					
		17. Father's Name	(First, Middle, La	st)		HOMEM	AKER	18. Mother's	Name (First, Midd		HOME			
Maryland	Mental h mrked of afic ever To Be	AARON				APAT	OFF	FANNI				ISHMAN		
lary	S should be send by	19a. Informant's N	Name/Retetionship	(Type, Print)	UII T	19b. Maitir	ng Address (Stree	et and Number o	r Rural Route Num	ber, City or Town	, State, Zip	Code)		
140	and and and and and and and and and and			/ DAUGHI				VALLEY	ROAD - VI	1				
JOE	H of H		□Cremetion 3	☐Removal trom S	State	cemetery, crei	natory or other p		Date	20c. Location				
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Ba	Depu	1	pH VI	Git	40.				SOL LEV	/INSON &				
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Box 68760,	th certificate be executed tending physician and or use as the burial-fransit an/Medical Examiner	Immediate Ceuse disease or conditi resulting in death) Sequentiatly list of any, leading to I cause. Enter Und Cause (Disease of that hitted even resulting in death)	conditions, Immediate Jertying or trijury	a b c	Due to (or as a consector as	quence of):	7(0n						
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0	thet the detacle detacle	BIPC	CAR	AFF	60	NE	DE	205	2 1	Yes 2 No	3 □ Pro	bably 429hknown		
Records,	been sign should be	coner	varry	An	122	y E	SIE	YSZ	24a. Wa	as en eutopsy formed?	8/	fere eutopsy findings vailable prior to empletion of cause death?		
	The law page 2	ANTER	i ain	DEA:	FNE	SS'	BUN	C	_ 10	Yes 2	11	☐ Yes 2☐ No		
Vital	yelclen: The last certificate he director, page	25. Was case refe examiner?	erred to medicat	110 20-1		1			Death (Check only	ath (Check only one)				
of	유 도를	1 ☐ Yes 2 ☐	9 No	1		28b. Time o	I 3LI DOA		ng Home 5 ☐ Re	sidence 6 Ot	-	(6)		
5	ding th.	Matural 2 Accident	5 Pending investigat	28a. Date o (Month	n, Day Year)	Injury	W	ork? □ Yes 2 □ No	200. 000010	o non injury occu				
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	n 24 hound in 24 hound he Funer pletchy fill edical	29e. Certifier (Check only one)	2 ☐ Medicai Ex	Physician: To the taminer: On the ba	sis of examine		vestigetion, in my	opinion, deeth o		e, date and place	, and due t	o the ceuse(s)		
	To To To To To To To To To To To To To T	29b. Signature and	d title of certifier	1.	/		29c. Lice	nse number	3/	29d. Date sign	ed (Month,	Dey, Year)		
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,	(1)	30. Name end add		o completed ceuse	of death (ite	m 23a) (Type,	Print) ICL	1312	SAIW	PICESV	LLE	MD 7170		
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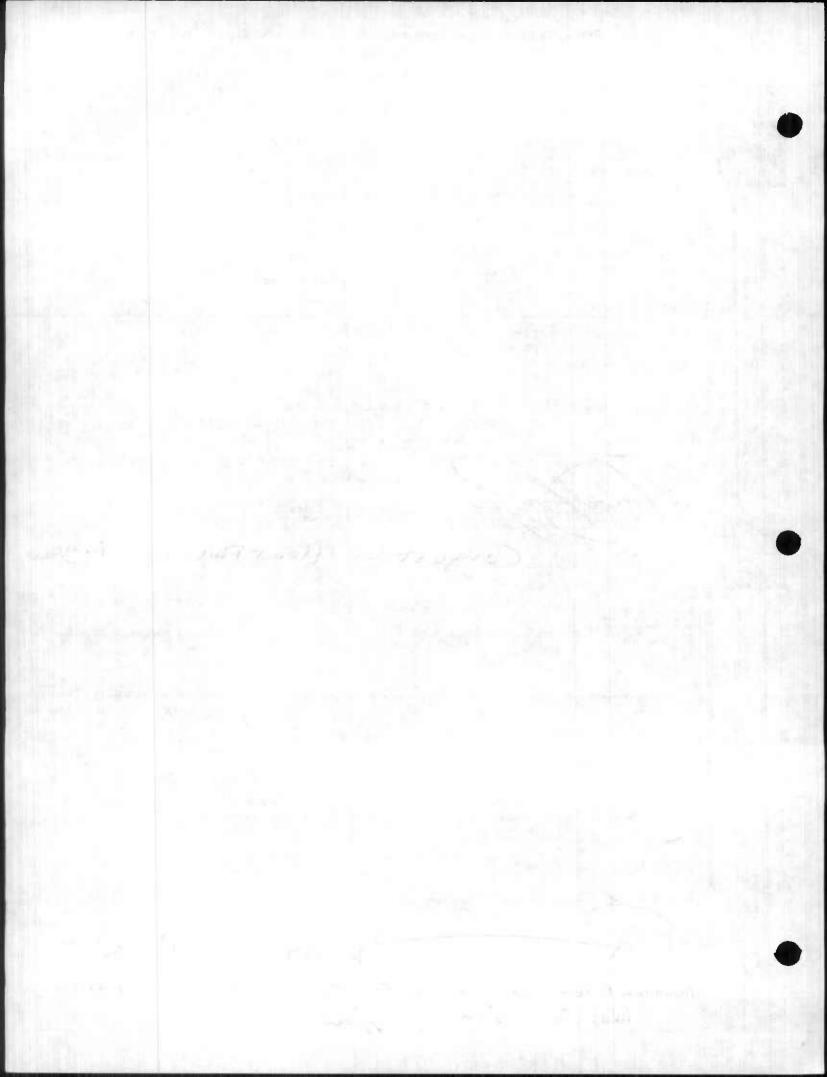


State of Maryland / Department of Health and Mental Hygiene 00 24786

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Examiner	4	la Fecility Name (If not institu CHERRYWOOD									ocation of Death		nty of Death		
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23a or 28a-1 s ant be nowhere al Director	1	8-D HIAWATH	IA CC	OURT			10f. Zi	p Code	2111	17		10g. Citizen	of Whet Cou	untry?	
ral', or itema 23a or 28a-f show Examiner must be notified at I by Funeral Director		11. Marital Status 1 ☐ Never Married 2 ☐ N 3 ☑ Widowed 4 ☐ Divorce		12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	cas? 2 No a	J,S. 1			dispanic Ori an, Mexicar Specify:		ecity Yes or No Rican, atc.)	- 14. F E Spe	lace - Amar lack, White city:	e, etc.	in,
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Important: I any injury o pnce.	100	21. Signature of Edneral Servi	00 1100	100	/		22. Nama e				SOL LEVI				
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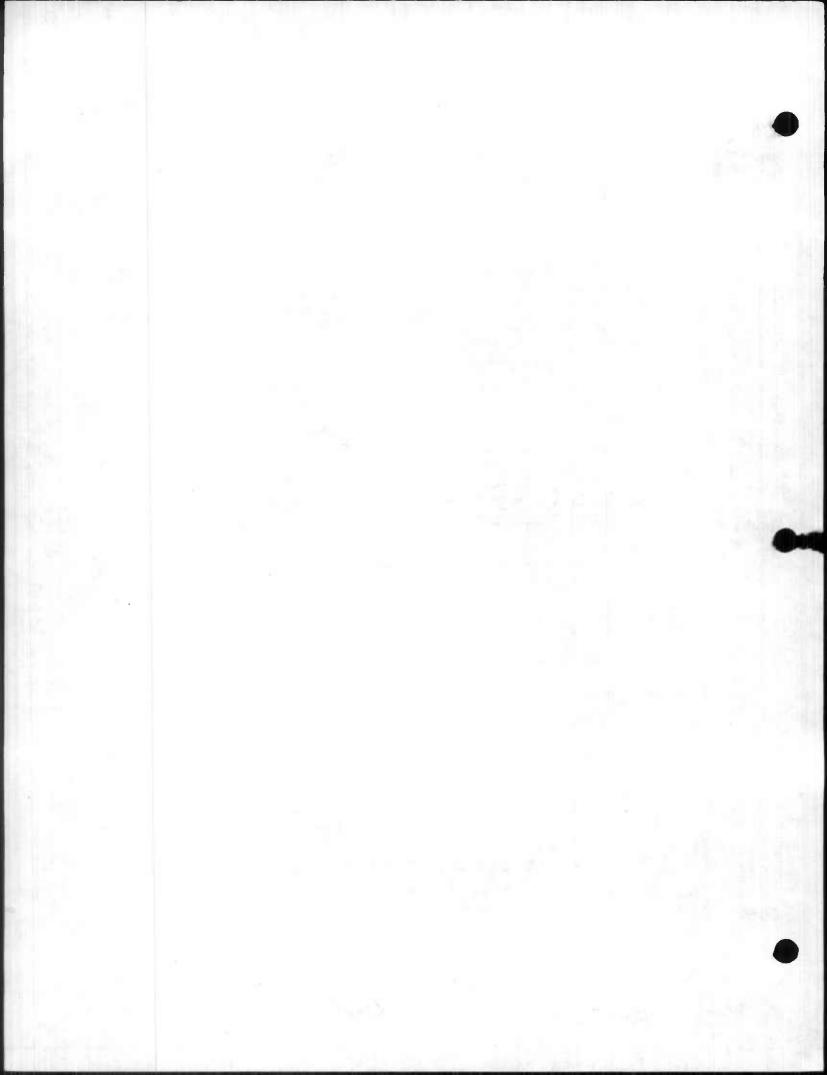


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State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate	e of	Death			Reg. No.	UU	24788
Name and Address of the Owner, where	1. Decedent's Name (First, Middle,	Last)							2. Date of Dec	ath	Wasa	3. Time of Death
Physician /Medical	Lawrence Edv	ward	Thomas						Month August	Day 6,	2000	7:53 PM
Examiner	4a Facility Name (If not institution,	give street and numb	er)			4	4b. City, To	wn, or Lo	cation of Death	4c. Cou	inty of Death	
	Saint Elizabeth	Nursing C	enter					imor	е	1	n/a	
Funeral		3. Sex 7. 1⊠ M 2□ F	Age (In yrs. last	10 000	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Birt (Month, Day	y, Year)	9. Birth	olace (Steta or Foreign
Director	213-10-2210 Usual Residence of Decedent		90	Yrs.					Jan 28	, 1910	Mar	yland
5 8 m	10a. Stata 10b. County		10c. City, To	own or Loc	ation							10d. Inside City Limits
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outh the Maryland t or 28a-f show be notified at Director	10e. Street and Number		Dur	LIMOL	10f. Zip	Code				10g. Citizen	of What Cou	ntry?
2 -4 -	637 Dover Stree	et			E 77	21	230			USA		
for death v r liens 23s siner mat	11. Marital Status	12. Was Decede		13. W	/as Deced	lent of H	lispanic Ori	igin? (Spe	ecify Yas or No- Rican, etc.)	14. [Race - Amari Black, Whita,	
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B 10 0 11 (3)	17. Father's Name (First, Middle, La	ist)						er's Neme	(First, Middle,	Maiden Sun	name)	
Vian Wented Wented To B	Frank C. Thomas	3						Suzi	e Horto	n		
Maryland d2 should be file not and Mental Hy lis marked oth traumatic event To Be	19a. Informant's Name/Relationship	p (Type, Print)	1	9b. Meiling	g Address	(Street	and Numb	er or Rura	al Route Numbe	er, City or To	wn, Stata, Zij	Code)
- 5965	Paul K. Thomas	/ son					eet,	Balt	imore,	Mary1	and 2	1230
More Pages 1.4 ent of He nut If Nem ry or oth	20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3	□Removal from Sta	20b. Place came	of Dispos tary, crem	atory or o	na of ther plac	ce)		Deta	20c. Location	on - City or To	own, Stata
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Physician /Medical	towardists Course (Final		0			11	Α.	1	- 1		į	Onset and Death
Examiner	tmmediate Cause (Finel disease or condition resulting in death)	a	(ong	esti	W	1100	est	10	eilure		- 1	Jaw weeks
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I Records, P.O. Box The lew requires that the deeth cent cate has been signed by the ettendin page 2 should be deteched for use. Completed by Physician/N	Part II. Other significant conditions	contributing to deat	h but not resulting	in the un	derlying c	ause giv	en in Part	1.	23b. Did 1	obacco use	contribute t	o the cause of death?
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n 24 hour n 24 hour ne Funera pletely filli	29a. Certifier 15 Certifying I	Physician: To the be aminer: On the basis	st of my knowled	ge, death	occurred a	at the tin	ne, date er	d place,	end due to the	cause(s) and	menner es s	stated.
	one)	and manner	stated.	WING MINE	Janyanon,	ar my o	prinori, ude	AT OCCUPY	over the trine,	care and pie	oo, end due l	o nie vadae(a)
To the to	29b. Signature and title of certifier	.0.1115			290	Licens	e number			29d. Date si	gned (Month,	Dey, Year)
	- Coletra La	pr up			1	X 15	>41			und ne	17,	2000
	30. Name and address of person wh	no completed ceuse of	of death (Item 23s	a) (Type, P	Print)		0	1.1.		1/1 5	2	
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State	31. Date filed (Month, Day, Year) AUG 0 7 200	A, 4367	of death (Item 23s Hollins stated.	fen	y Ro	d,	1ball	An	gru , "	4D - 0	(122	7 .

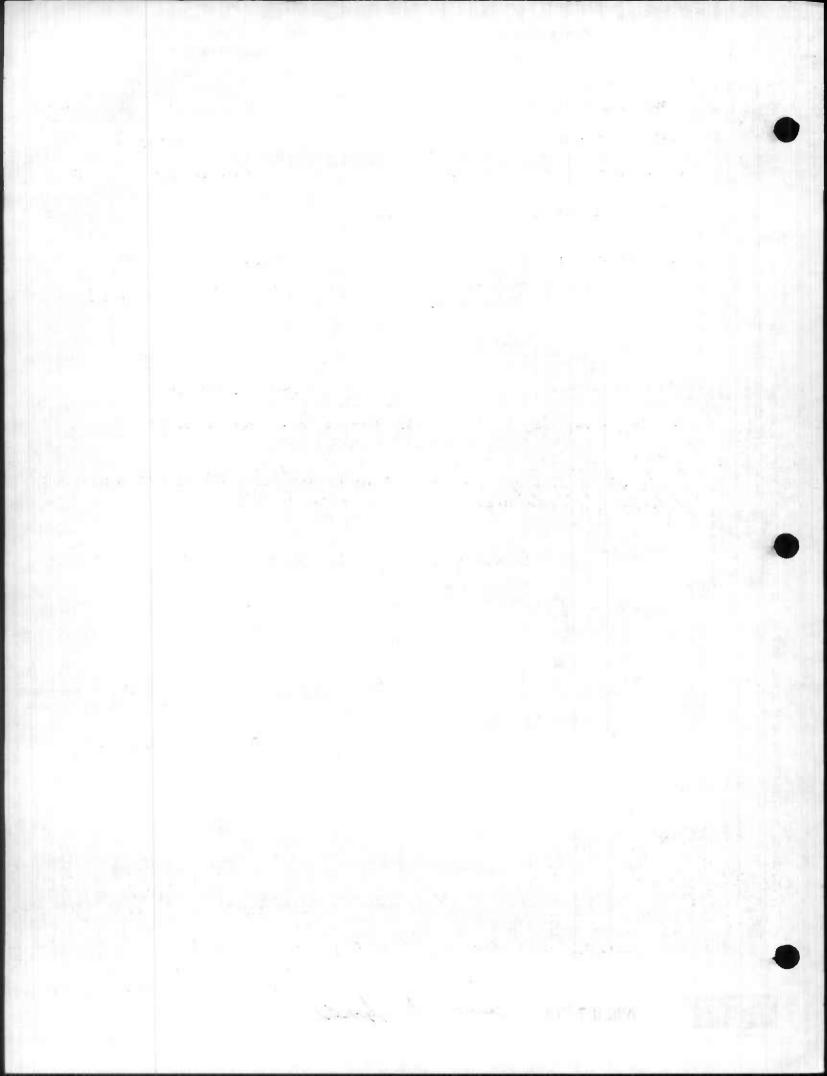


Please Type or Print in Biack indeiibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'e Name (First, Middle, Last) 3. Time of Death 2. Deta of Deeth Month **Physician** ROBERT-JOHN TRAPANI JULY 28, 2000 3:00 AM · /Medical 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1410 Stratton Drive Rockville Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yaar Birthpleca (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 X M 2□ F Months Deys Yrs. 078-24-4216 Director 70 Sept 8, 1929 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic svent, the Modical Examiner must be notified at the Maryle MD Montgomery Rockville 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1410 Stratton Drive deeth Funeral 20854 USA 14. Raca - Amarican Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armad Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 150-54 Was Decadant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours efter 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within imment of Health end Mental Hygiena.
Ortant: If Item 27 is marked other than "rightry or other traumatic svent, the Men Elementery/Secondary (0-12) College (1-4or 5+) +5 immunologist health 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be James. A. Trapani Diana M. Pandolfin 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 20854 Jean Trapani/spouse 1410 Stratton Drive Rockville, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ RemovaLtrom State permit. Page Department of Important: If any Injury or once. 4 Donetion 5 ☐ Other (Specify) 21 Signature of Facetal Service Scotts Wade, Director 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Part Enter the diseasa, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** two /Medical Immediete Ceuse (Final diseese or condition resulting In deeth) e. Congrative Utust Fuilure Yeur Examiner Due to (or es e consequence of): Examiner physician end the bunal-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760 Physician/Medical Due to (or es e consequenca of) 98 attending p ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? P.O. signed by d 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. by 24b. Were eutopsy findings evailable prior to complation of cause of deeth? 24a. Wes en eutopsy Completed peed hes page 2 1□ Yes 20 No director, 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: After 1 Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No daath. Investigetion or Attendation of the other of 6 Could not be To the Hospital or Atte within 24 hours after da. To the Funeral Directo completaly filled in by the 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29b. Signeture end title of certifiar 29c. License number 29d, Dete signed (Month, Dev. Year) 3/ 031834 30. Name end eddress of period who completed causa of death (Item 23e) (Type, Print) 615 West montgomer Dontora, Chult boht 170 mo nockvilla 32. legistrar's Signeture AUG 0 7 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 Mm ON ELLINGTON 2000 /Medical 4a Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Medical Center TOWSON 6. Sex. 1 M 2□ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Min Yrs Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 509 USA 21204 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Rece - American Indien, Black, White, etc. 11 Meritel Stetus il Hygiene. other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black py 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tem 27 is marked other any injury or other traumatic event phose. 18. Mother's Neme (First, Middle, Malden Sumame) 17. Father's Neme (First, Middle, Last) VIa 19a. Informent'a Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Cir. Batto. MO 21244)r-father 20 Mountain Green Milton Tellington. 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece 20e. Method of Disposition 1 ABuriel 2 □ Cremetion 3 □ Removel from Stete King Memorial 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funerel Service Licensee TRISTATE Oles 108 w. North Ave -21201 Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ONARY Examiner Examiner burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Box 68760 Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Nas 2 No 3 Probably 4 Unknown 2 þ Division of Vital Records. 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Medical Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury et Work? 1 Suleturel 5 Pending Injury 1 Yes 2 No To the Hospital or Attendir within 24 hours effer death.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifier (Check only and manner stated 29d. Dete aigned (Month, Day, Year) 29b. 5 m 29c. License number

Registrar

State

RABHAKAR

32. Registrer's Signeture

300 ARMORY/LACE

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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31. Dete filed (Month

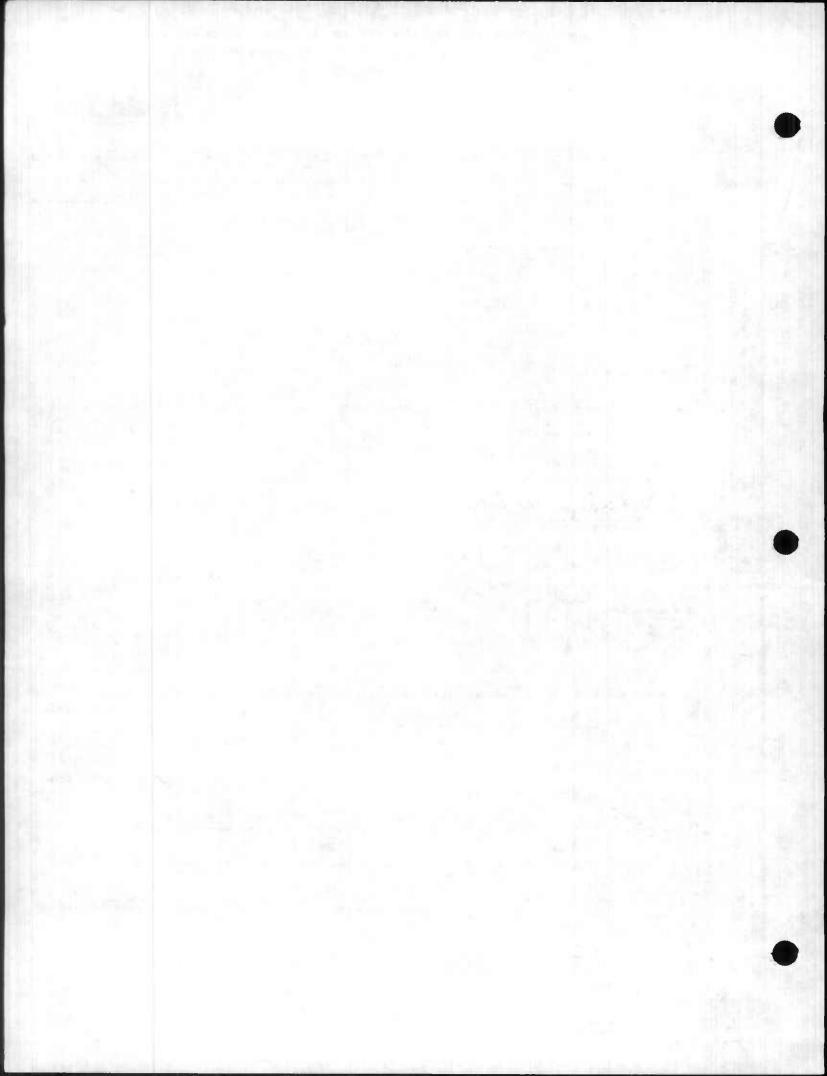
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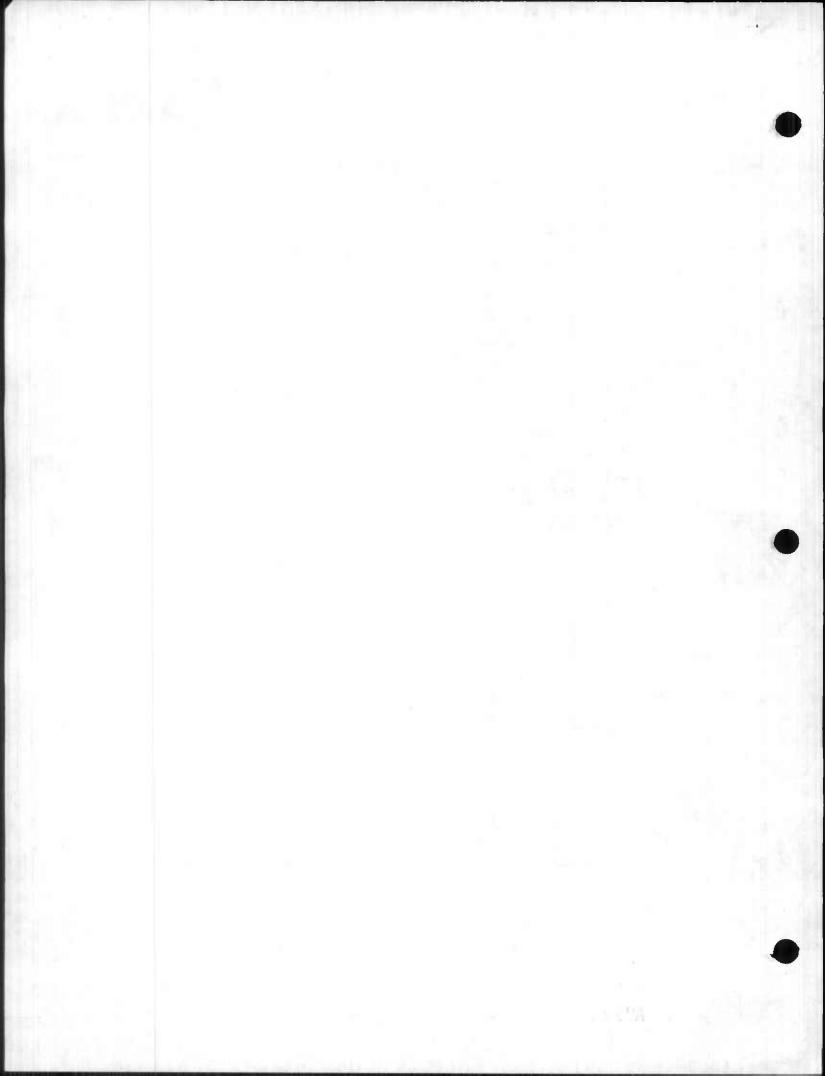
ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 1 24792

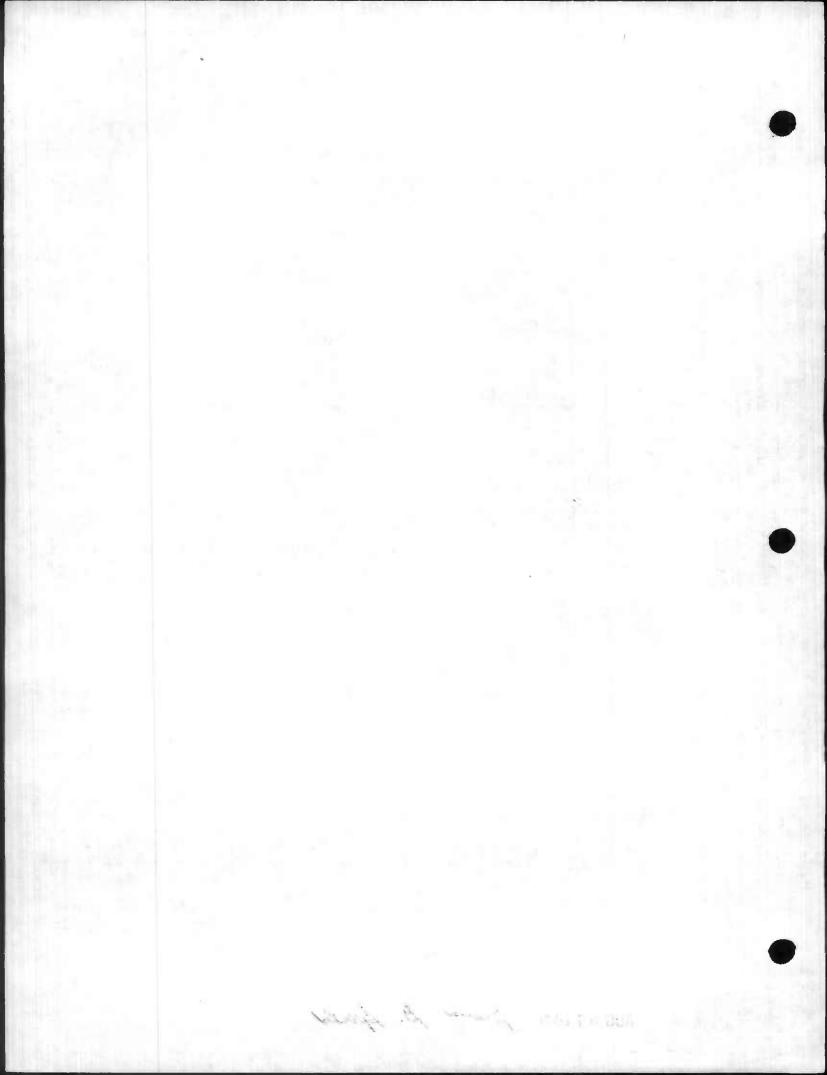
						(Certifica	ate of	Death		F	leg. No.	J		
		1. Decedent's Name (2. Date of Dea Month	th Day	Year	3. Time of Death					
Physician /Medica		Robert Lo	uis Will	nelm, Jr.							August	05	2000	09:01 A.M.	
Examine		4e Fecility Neme (If n	ot institution, giv	e street and numbe	r)	1	100		4b. City, To	wn, or Loc	ation of Deeth	4c. Count	y of Death		
				gnes Hosp						ltimo			N/A		
Funeral Director		5. Social Security Nun 213-64-45 Usual Residence of D	76	6ex ▼ M 2□ F	Age (In yrs. 49		Month	der 1 Yeer is Days		Min.	8. Date of Birth (Month, Day lay 22,	, Year)	Cour	place (State or Foreign ptry) rland	
B 1	1		Ob. County		10c. City	y, Town	or Location						1	Od. tnside City Limits	
Maryta 4 sho led at	ò	Maryland	Raltimos	**	Balt	-i mo	***							1 ☐ Yes 2 ☐ No	
or 28s-f sho or 28s-f sho	Director	10e. Street and Numb		Le	Dait	LINO		Zip Code				log. Citizen of	What Cour	ntry?	
0 0 0										United States					
ner daug herma 2 her man	Funeral	11. Merital Status	arne Rot	12. Was Deceder		S.			Hispenic Ori	gin? (Spec	ify Yes or No- ican, etc.)		ce - Americ	en Indian,	
020 on a	þ	1 Never Married 3 □ Widowed 4		Armed Forces 1 Yes 25 If Yes, Give Year or Dates	No			-	Specify:		ican, etc.)	Speci	ick, White, fy: Wh	nite	
5-0 72 h	Completed		5. Decedent's Ed			16e. [Decedent's U	sual Occu	petion during most	t of workin	q	16b. Kind ot 8	Business/In	dustry	
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E = 04 h	1	Walter C. 20a. Method of Dispos		tein - bro	20b. P	leca of [Disposition (/	vame of		, Dal	Ltimore Date	, Mary. 20c. Location		21229 own, State	
altimore, mit. Pages ta partment of Nea portant: If New y Injury or othe		1 ☐ Burial 2 💢	Cremation 3 [Removel from Stat	e c	emetery	crematory o	r other pla							
Hin Park	-	4 Donation 5			Met	ro	Cremat				7/00			e, Maryland	
Bany tempo		> Un	nl	1. Zin	D					4107 Balt	ard Fu Wilke	ns Aver Marvla	nue	inc. 21229	
	23a. Part 1. Enter the disease, or complication. that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one count on each line.									cerdiac or	iac or respiretory errest, Approximete Interval Between Onset end De				
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Hypertensive Arteriosclerotic Card: Due to (or as a consequence of):										ovascu	lar Dis	ease		
R E	Examiner														
60, be executed icien and bunal-transit	хаг	Sequentially list cond	itions,	0.	Due to (o	rasaco	nsequence o	of):							
S 5 5 5		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.													
68760, ufficate be an g physician as the buna	edicai	that Initiated events resulting in death) Las			Due to (or	reseco	nsequenca o	ot):							
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that the death cered by the attendir detached for use	by Physician/N	Part II. Other significa	ant conditions o	ontributing to death	but not res	ulting in	the underlyin	g ceuse g	iven in Part I		23b. Did t			o the causs of death? bably 4 Unknown	
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The law ate has page 2	D D										40.	1		_ v	
Vital Rictaria The certificate h		or W	d A dt. a l								1 D Y		11	Yes 22 No	
of Vita Physician: this certific	Be	25. Was case reterred examiner?		Hospitel:				0	ther		(Check only o				
Phys this said	O	27. Manner of Death)	1 ☐ tnpa 28a. Date of Ir	23	ER/Outp		DUA	4UNU		e 5 Resid			(y)	
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Division of or Attending Physiatra death. Director: After this 3 in by the funeral di	Certification:	2 ☐ Accident 3 ☐ Suicide	6 Could not b	e one place of	niury - At ho	ome, tarr					8t. Location (S	Street and Nun	ber or Run	al Route Number,	
Div aftar	ert	4 Homicide	determined	building,	etc. (Specif	y)			-		City or Tow	m, State)			
\$ 5.2 Q	29a. Certifier 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place and menner stated.														
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F3F8		10	. / -	V. MAN)				O.C.M.E.					2225	
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O		30. Name and address J. Laron					* *	+	+ p-1	4-2			21201		
0		31. Date filed (Month,			strar's Signa		Term S	, cree	c, Bal		re, Mar	ATSU	21201		
State Registra	_	AUG	07 200	0 Sen	wer	19	de	all	3						



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			W.G.	Certifica	ate of De	ath		Reg. No.	10-310	
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Examiner	4a Facility Nama (If not institution	give street and nymber,	011	118	4b. C	city, Town, or	Location of Death	4c. County	of Death	
	University	NARY and	rred	ical ye	stem 1.	BUH	mone			
Funeral Director	none	5. Sex / 7. Ap 1. 1 M 2□ F	ge (In yrs. last b	Yrs. Month		Undar 24 Hrs. lours Min. 4	8. Data of Birt (Month, Da) July 8		9. Birthplace Country)	a (Stata or Foraign) MD
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or 28s-1 s or 28s-1 s be notified	10e, Street and Number				Zip Coda			10g. Citizen of V	Vhat Country	7
				101.		006				
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Annta Annta					T	iffany	Whittin	gton		
of the second	19a. Informent's Name/Relationshi	p (Type, Print)	19	b. Meiling Addra	ass (Street and	Numbar or A	ural Routa Numbe	er, City or Town,	Stata, Zip Co	ida)
20,000	Tiffany Whitting	ton/mother		5619 Wai	lther A	venue	Baltimo	re, MD	21206	
Pages 1 and of He and of H	20a. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 4 ☒ Donation 5 □ Other (Spirit	B □Ramoval from Stata	20b. Placa	of Disposition (fi ary, cramatory of	Vama of		Data	20c. Location -	City or Town,	, Stata
Departm Departm Imports any Inju	21. Signature of Funeral Service L		rector		and Address of Anaton			. Balti	more S	treet
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Physician: this certific ral director.	axaminer? 1 ☐ Yas 2 ☑ No	Hospitel:	iant 2 ER/C	Outnationt 3	Other		Homa 5 ☐ Rasi		ar (Specify)	
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or Attending I after death. Director: After 3 in by the funer ertification	1 Natural 5 Panding 2 Accident Invastige		ay Year)	Injury		2 🗆 No				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no detarmin	Zoa. Flaca of III	njury - At homa, (c. (Specify)	farm, street, fact	tory, office		28f. Location (: City or To	Street and Numb vn, Stata)	er or Aural A	outa Number,
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in al		BERT L. WA								Month UGUST	Dey	Yeer)00	6:55 A.
i	4a Facility Name	(If not institution, giv	re street and num	nber)			4	b. City, Town			4c. County	-	
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	5. Sociel Security 231–32–	9794	Sex 1CM 2CF	7. Age (In yrs. 67	last birthday) Yrs.	If Under 1 Months C	Year Deys	If Under 24 Hours	Hrs. 8. Min. F	Date of Birth (Month, Dey, eb 1,	Ĭ935	9. Birthple Count	nce (State or Fore
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by Funeral		rried 2 Nerried 4 □ Divorced	12. Was Dece Armed For 1 X Yes If Yes, Give Yeer or De	ces?		Was Deceder f Yes, specify 1 ☐ Yes 2 ②	/ Cuba	ispanic Origin n, Mexican, I Specify:	n? (Specify Puerto Rici	y Yes or No- an, etc.)	Bled	14. Race - American Indian, Bleck, White, etc. Specify: black	
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1	21. Signeture of Euneral Service Licensee Royald S. Wade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201												
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											est,	1	Approximete
ı	23a. Part1. Enter shock, or he	the disease, or come eart failure. List only	plications that ca one cause on ea	used the dea ech line.							est,	1	Approximete Intarval Batween Onset end Death
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00-4366-510 jhm SHERMAN WISNER

Piease Type or Print in Black Indelible Ink. Assure Ail Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

partment of Health and Men ertificate of Death	Reg. No.	64120
partment of Health and Men	ital Hygiene	21.795

Physician /Medical Examiner

1. Decedent's Nama (First, Middla, Last) Sherman Robert Wisner 2. Date of Death Month Day AUGUST 03, 2000 3. Time of Death

10d. Inside City Limits

1√ Yes 2 No

4a Facility Nama (If not institution, giva street and number) UNION MEMORIAL HOSPITAL

10b. County

4b. City, Town, or Location of Death

BALTIMORE

16:12 PM 4c. County of Death

Funeral Director

or 28a-f ahow

than "naturel", or items 23s or 28s-f ahor the Madical Examiner must be notified at

death

filed within 72 hours after

I Hygiene.

.. Pages 1 and 2 should be fill the of the health and Mental H tant: If them 27 is marked off jury or other traumatic even

permit. Pages 1 end 2 Department of Health e Important: If them 27 le eny Injury or other tree

Maryland 21215-0020

Baltimore,

Funeral

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Be Completed

215-09-8171 Usual Residence of Decedent 7. Age (In yrs. last birthday) Days Yrs.

8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Undar 24 Hrs. Oct.29,1917

 Birthplace (State or Foreign Country) Balt.

10a. State Directo MD

10c. City, Town or Location Baltimore

82

10e. Street and Number

5. Social Security Number

10f. Zip Code 21211

10g. Citizen of What Country? U.S.A.

834 Powers Street 11. Marital Status

1 Never Married 2 ☐ Married

12. Was Decedent Ever in U,S. Armed Forces? 1 ∏ Yes 2 ☐ No MYes, Give Year or Dates: 1941-1945

13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

MM 2□F

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondery (0-12)

Mechanic

Transportation 18. Mother's Name (First, Middle, Maiden Sumame)

17. Fathar's Nama (First, Middla, Last)

Sarah Ruth Morris

<u>Sherman G. Wisner</u>

19a. Informant's Name/Relationship (Type, Print) Sister

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 115 W. Chestnut Hill Lane, Reisterstown, MD 21136

Mrs. Patricia Hasert 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 8/08/2000 Elkridge, MD

1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

Meadowridge Cemetery 22. Name and Address of Facility

11824 Reisterstown Rd.

21. Signature of Funeral Service Licensee

time Eline Funeral Home rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, ock, or heert failure. List only one ceuse on each line.

MD 21136 Reisterstown, Approximata Interval Between Onsat and Death

Physician /Medical Examiner

The law requires that the deeth certificate be executed

Box 68760.

P.O. |

Division of Vital Records,

Hospital or Attending Physician:

To the

death.

after death

within 24 hours at To the Funeral O completely filled

filled in by

Physician/Medical Examiner

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Be Completed

edical Certification: To

the

88 USB

ate has been signed by page 2 should be detec

After this

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediata Causa (Final

disease or condition resulting in death)

Atherosclerotic Cardlovascular disease Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

Inspection 1 Yes 2 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 XYes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number OCME

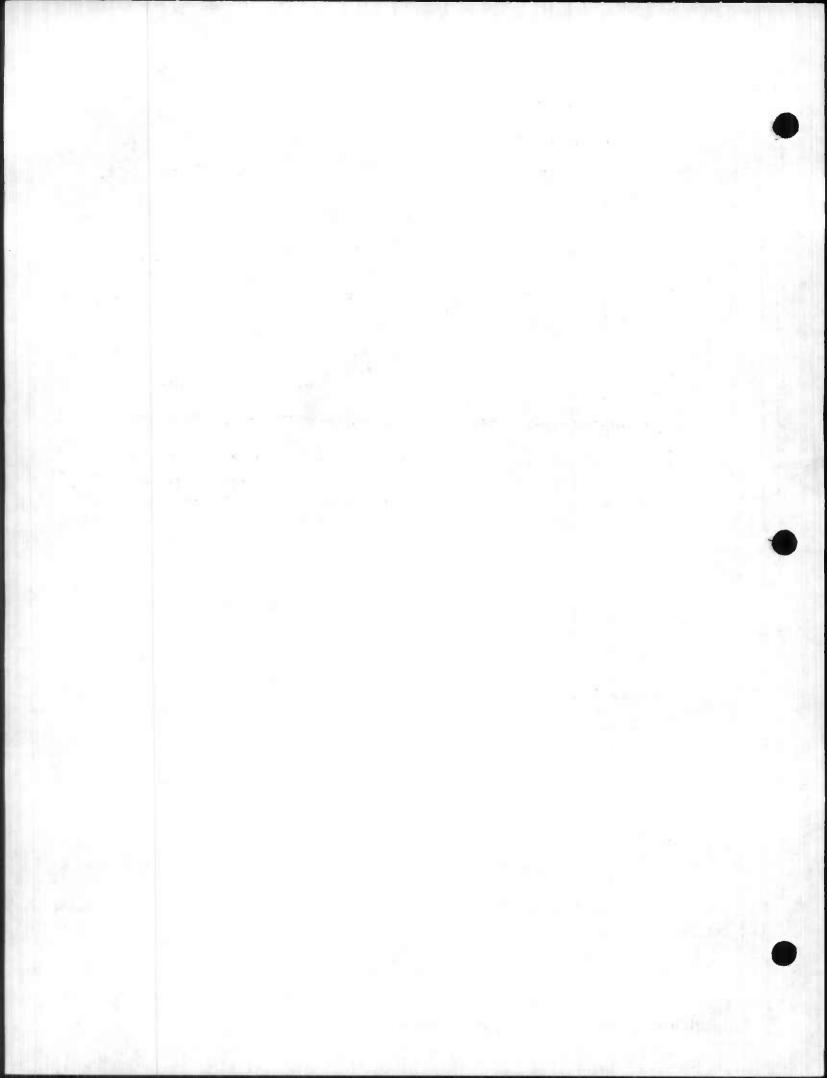
29d. Data signed (Month, Day, Year) AUGUST 04, 2000

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Stephen 31. Data filed (Month, Day, Year) Radentz, 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura

AUG 0 7 Registrar 2000 oorks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Harry G. Wianke, Jr. 22:11 Aug ust 4b. City, Town, or Location of Death 2000 1 2 000 4c. County of Deeth 4a Facility Name (If not Institution, give street and number) Raltimore TUndar 24 Hrs. Hours Min. Oct. 11,1936 Hospital of Bultimore Sinai ff Under 1 Yaar 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 1♥M 2□F 63 Months Days 217-30-5134 Yrs. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Reisterstown Baltimore 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? USA 21136 714 Westminster Pike 12. Was Decedent Ever in U.S. Armed Forces? 1 29 Yes 2 □ No If Yes, Give Year or Dates: 1957–1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manufacturing Factory Worker 12 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Martha Harmon Harry G. Wianke, Sr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 714 Westminster Pike, Reisterstown, MD 21136 Friend Evelyn Ruby 20a. Method of Disposition 1 Disposition 3 Removal from State 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stafe Garrison Forest Vet. Cem. 8/7/00 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD sans 3a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Betw Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Gastrointestina Due to (or as a consequence of) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury final initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of) Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hepatocellular Cancer 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1□ Yes 2☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner

Physician

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

8 238

8

Pages 1 and 2 should be need of Health and Mental ant: If Nam 27 is menked o

Department of Health Important: If Item 27

Maryland 21215-0020

Physician/Medical Examiner Medical Certification: To Be Completed by after death.

I Director: After in by the fu

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, or Attending

within 24 hours a To the Funeral C completely

State Registrar

Dissolado 31. Dale filed (Month, Dey, Year) AUG 0 7 2000

29b. Signature and title of combine

1 Natural

2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

29c. License number

WEST

1 Yes 2 No

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

dress of person who completed cause of death (ftem 23a) (Type, Print)

28e. Placa of Injury - At home, farm, straef, factory, offica building, etc. (Specify)

August 2, 2000 21215

Belverare AVE. BALTIMORE

Lvlandez 2401 32. Registrar's Signatura

5 Pending investigation

6 Could not be

books

DHMH 16 Rev 6/95

Hospital

To the

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** August 5:25 am Lucille P. Wade 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE KOSEDALE 8. Data of Birth (Month, Day, Year) 9. Birthpiaco (Country) Country) July 22, 1921 Washington DC 5. Social Security Number if Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (Steta or Foreign Country) **Funeral** 10 M 70 F Months Days Hours 79 Yrs 373-22-3689 Director Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 No 28a-f Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 3005 Dunglow Road 21222 Funeral 12. Was Decedant Evar in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Detes: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Ves 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. School Teacher Education 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Willie Patterson Melinda Woolridge 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Pages 1 and 2 si ment of Health an tant: If them 27 te Abdul Jamaludeen / Son 139 East Virginia Ave. Hampton, Va. 23663 20b. Place of Disposition (Name of cematary, crametory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. | 8/5/00 | Baltimor 22. Nama and Address of Facility Cremation Society Of Maryland Inc. 8/5/00 Baltimore, Maryland 21. Signature of Funaral Sarvice Igicensee Thomas Gregor 299 Frederick Road Baltimore, Md. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in death) /Medical · Pulmonary Embolism 8 hours Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or as a consequence of): Box 68760. Dua to (or as a consequence of): USB as 1 P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Ware eutopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 1 Yes 2 No 2 No Physician: 25. Wes case referred to medical examiner? 26. Pleca of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this 27. Memoer of D t Nulatural er of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Injury et Work? After or Attending 5 Pending invastigation death. 1 Yas 2 No 2 Accident the 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

after death filled in by To the Hospital o within 24 hours at To the Funeral DI edical 0 0

29a. Cartifier

12 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete and place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the ceuse(s) end menner steted. (Check only one) 29b. Signature and titla of certifier

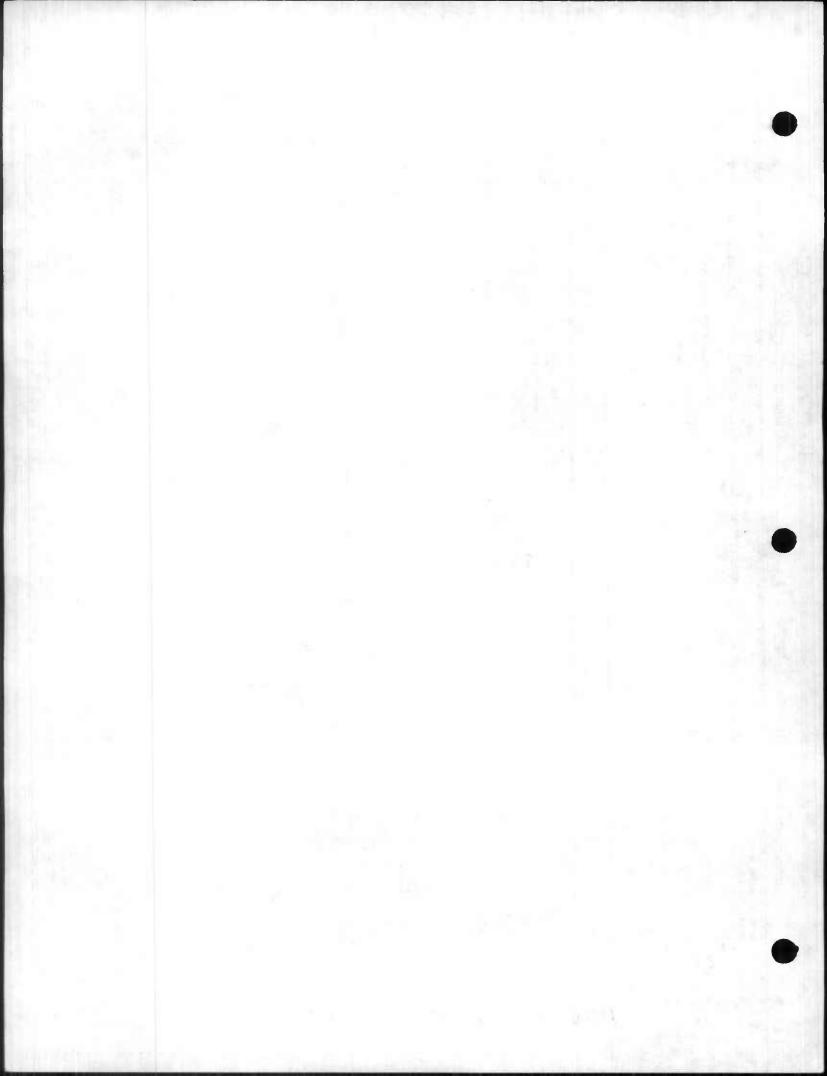
29c. Licansa number 4 do 29d. Date signed (Month, Dey, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

ARBI GHAZARIAN, MD; 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Data filed (Month, Day, Year) 32. Registrar's Signetura AUG 0 7 2000 Genera



Please Type or Print in Black Indeible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Yee Month Physician Robert Henry Wright 4:20am 31, July 2000 /t/tedical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice Baltimore NA If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Funeral Days Months Hours 10M 20F 218-30-1333 64 03-29-36 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No NA MD Directo Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? or Items 23s or 1520 E. Madison Street 21205 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Furniture 10th Grade NA Laborer Construction Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 William James Wright Adeline Ringgold 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21201 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health as Important: if Item 27 is any injury or other trau Emma Brown Weldon 804 West Saratoga Street Baltimore, MD. 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 08-04+2000 Dundalk, MD 22. Name end Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses mous WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical NGEAL CARCINOMA Examiner Examiner physician and the burlai-transit Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? should be deteched Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tos 2 No 3 Probably 4 Unknown P 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director. 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Wother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 ENatural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune 1 Tyes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, lactory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Dete signed (Month, Dey, Year) mp. DO 6933 JULY 319

Registrar

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LOND B

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

altimore,

00/

Robert Wright

to

Division

ORIGINAL

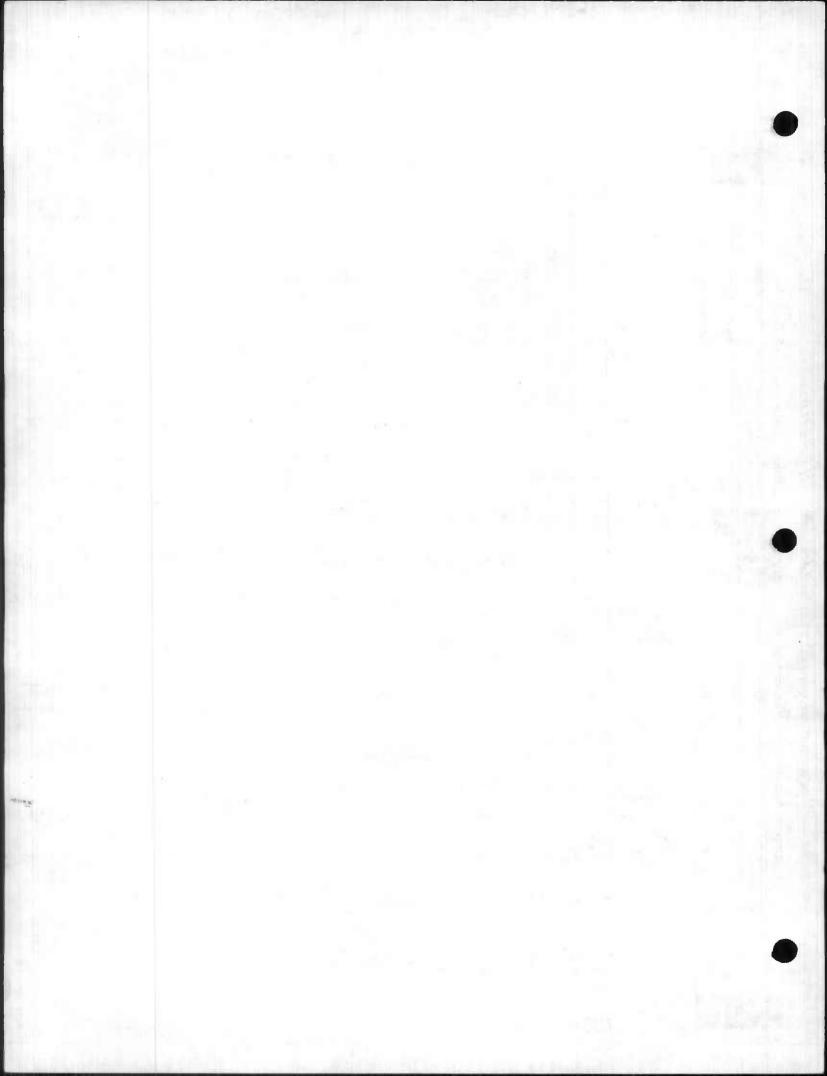
300 ARMORY PIRE SUITE 3G BALTIMORE NO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACGIBBON M.D.

AUG 0 7 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death		Reg. No.	00	69177
Dhuaisian	1. Decedent's Name	e (First, Middle, Last)					2. Dete of Month	Death Day	Year	3. Time of Death
Physician /Medical	Betty			L	JelK			Augu	st 3, 2	000	09:20
Examiner	4a Facility Nama (II	not institution, giva	street and nur	mber)			4b. City, Tow	n, or Location of De			
7	Johns Ho	opkins Bo	zyvieu) Medica	ul Cen	ter	Baltin		Ball	himore	e city
Funeral	5. Social Security N	4.5	X DM 2LZF	7. Aga (In yrs.		If Under 1 Year Months Days	If Undar 24 Hours		Birth Dey, Year)	9. Birthplac	ce (State or Foreign
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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician ANNA** YOFFEE 3, August 2000 6:10pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore N/A 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2XF Months Hours Director 213-50-0696 90 APR. 29, 1910 POLAND Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits No Yas 2□ No Director MD N/A BALTIMORE 288-1 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23s or 5925 BLAND AVENUE 21215 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yas 2 X No If Yes, Giva 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify: Specify. WHITE p 3 Widowed 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 SALESPERSON WHOLESALE GROCERY altimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be 8 and Mental JOSEPH SCHUCHMAN **JESSE** KLEPETCH 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mportant: If them 27 is 5925 BLAND AVENUE - BALTIMORE, MD 21215 REUBEN H. YOFFEE / HUSBAND 20b. Piece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AGUDAS ACHIM ANSHE SFARD 8/4/00 ROSEDALE, MD 4 Donetion 5 Other (Specify) 21. Signatury of Funeral Service License 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 234 Part f. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximate Intarvel Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in daeth) Sepsis as a result of Ischemic Right Foot Examine Dua to (or as a consequence of): Examiner The law requires that the death certificate be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 1 has 2 No 1 Yas 1 Yes 2 No 25. Wes casa refarred to medicel axaminar? Be 26. Place of Death (Check only ona)

Box 68760. certificate this After death.

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P.O. Records. Division of Vital Attending Director: / 3 hours after 8 within 24 hours aft To the Funeral Di completely filled in Hospital

Medical To the Within 2

Certification: To

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Deepak Kashyap, MD., 31. Date filed (Month, Day, Year) AUG 0 7 2000 State Registrar

29a. Certifian

1 Yas 2 No

27. Manney of Death

1 Netural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

2401 W. Belvedere Ave., Baltimore, MD 32. Registrar's Signatura

1 PInpatiant

28a. Data of Injury (Month, Day Year)

Hospitel:

5 Pending

invastigation

6 Could not be detarmined

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated.

29c. License number

P13207

1 Yas 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

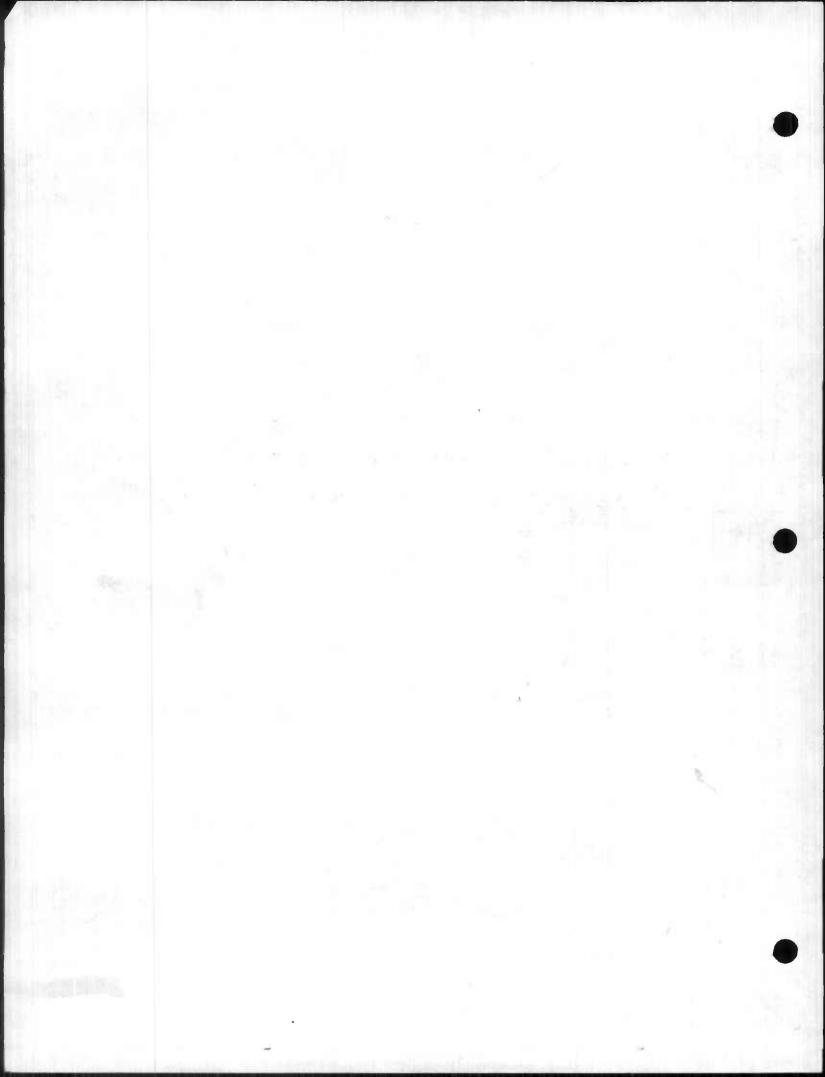
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29d. Date signed (Month, Day, Year) August 4, 2000

2 ER/Outpatient 3 DOA

28b. Tima of

Piece of Injury - At home, farm, streat, factory, office building, etc. (Specify)



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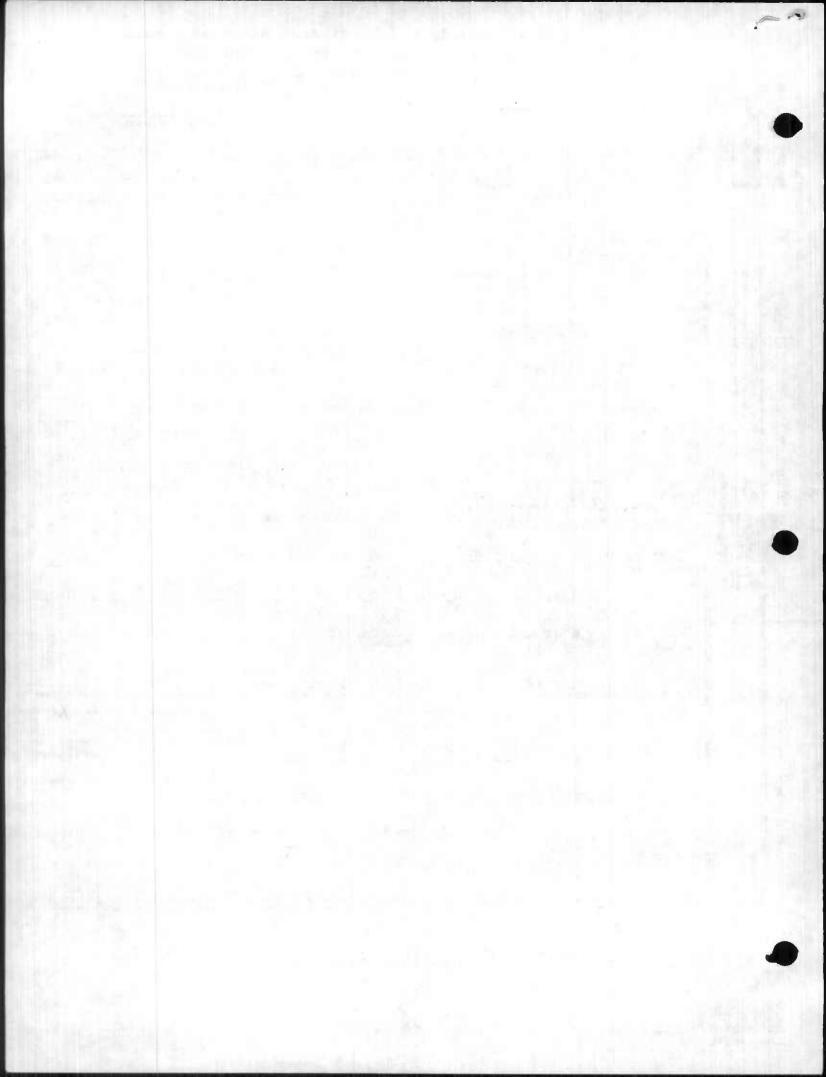
State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 28c per phys. G786 8/4/00State of Maryland / Department of Health and Mental Hygiene 24802 yg M.W.O. Certificate of Death 7/20/00, Howard Co., Amended #1. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Louis Allen **Physician** 2000 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner rore nivursi None If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numb 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days Min 10℃M 2□ F Dec 22, 1929 Pennsylvania Director 111 24 7249 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location t0d. inside City Limits items 23a or 28a-f ahov the Medical Examiner must be notified at 1 Yas 2X No Directo Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8304 Govenor Thomas Lane 21043 United States Funeral deeth 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours efter 1 2 Yes 2 No
If Yes, Give
Year or Dates: 1951-75 1 Never Married 2 Married 8 Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White "natural" Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Cotlege (1-4or 5+) Etementery/Secondary (0-12) Signal Communications US Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Hauth and 2 should be fi Hauth and Mental H Iam 27 is marked off John Clifford Allen Eunice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health If Itam 27 i Jean L. Allen/Wife 8304 Governor Thomas Lane Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Pages ment of h 1 ☑ Burial 2 ☐ Cremation 3 ☑Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 7-25-2000 Arlington, Virginia 21. Signature of Funeral Service Licensee mology 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. Collins all 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examin The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last es the burial-tran ate has been signed by the attending physician page 2 should be detached for use as the buria HYPERTENSION Portal Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes this certificate Physician: eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28d. Describe how injury occurred Medical Certification: 28b. Time of or Attending P 5 Pending investigation 1 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signature and title of contille 29d. Date signed (Month, Day, Year) 29c. Licensa number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 31. Date filed (Month, Day, Year). 32. Registrar's Signatura State 2 0 2000 Registrar



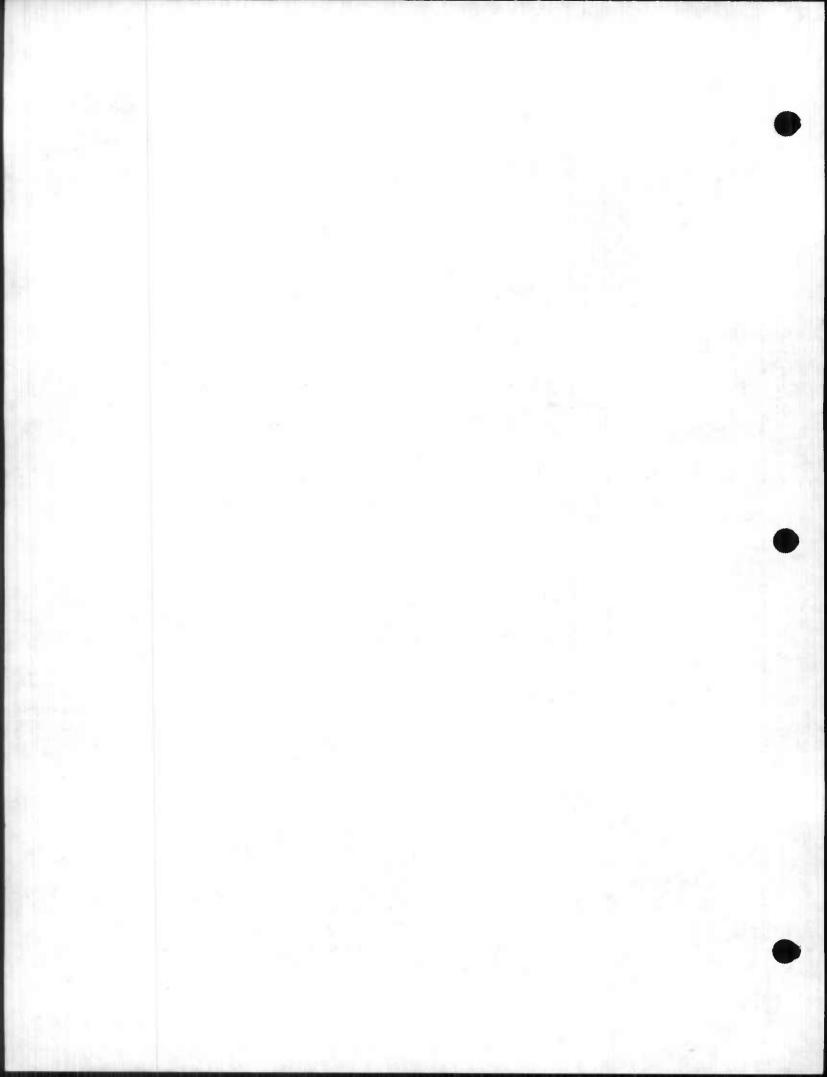
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State of Maryland / Department of Health and Mental Hygiene

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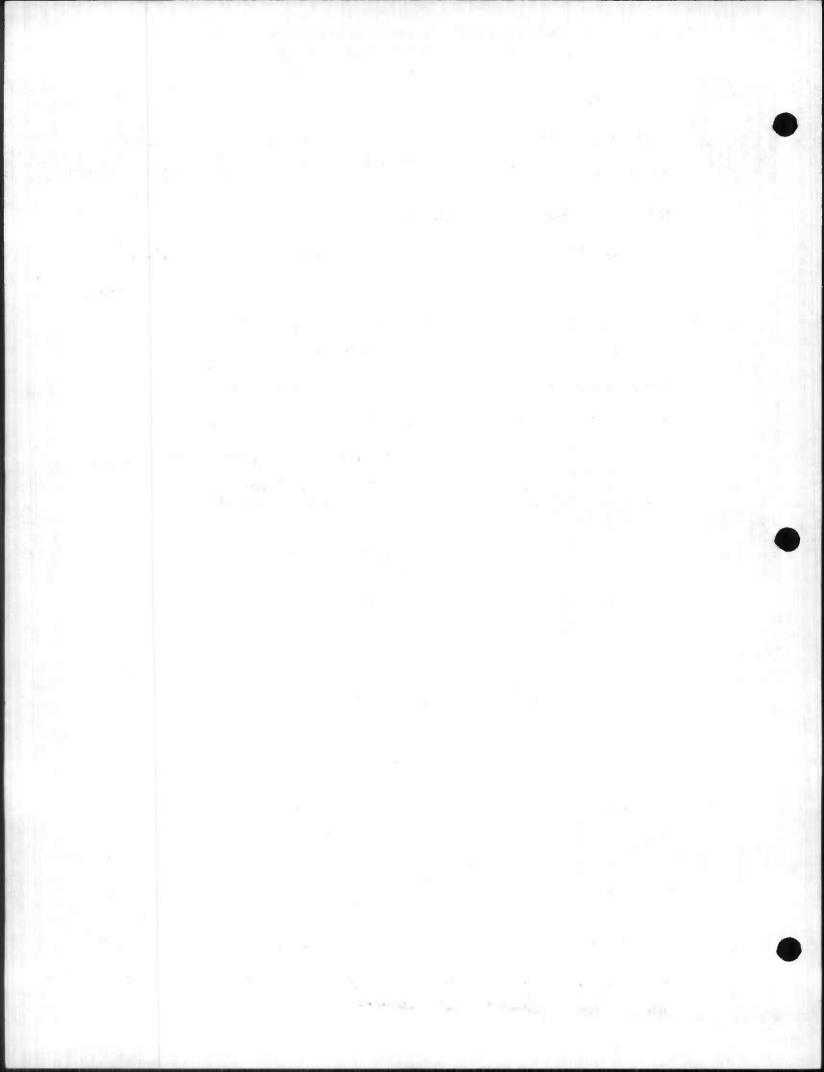
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State of Maryland / Department of Health and Mental Hygiene 00 24804

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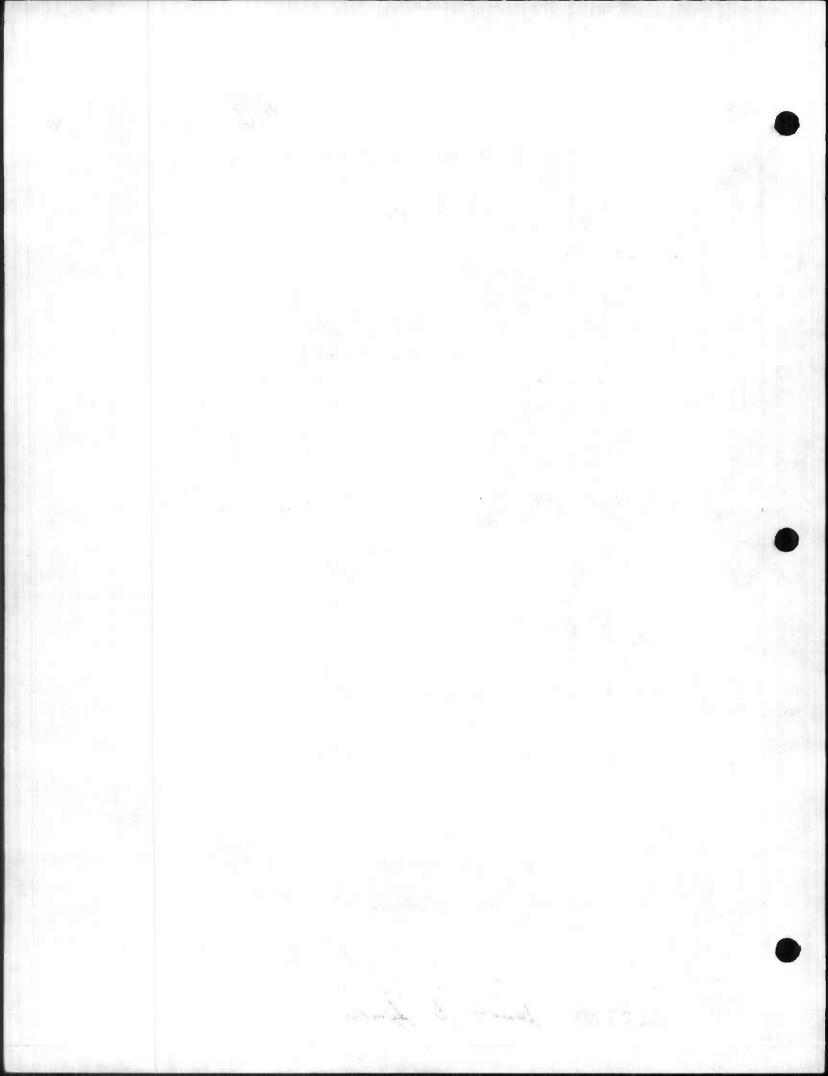
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State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey 2000 July **Physician** 22, 9:50 P. M. Elvwn Overton Bowers /Medical 4e. Fecllity Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Homewood Retirement Center Williamsport Washington If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** TI, 1911 1□M 2 F North Carolina 217-12-1400 88 Director Usual Residence of Decedent the Maryland 10a Stete 10d. inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumetic event, the Madical Examinar naish be notified at Yes 2□No Director Washington Maryland Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1123 Moller Avenue 21740 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

Important If tem 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exprin 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) L. P. N. Williamsport Nursing Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) James Warren Overton Maude Montero Spruill 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Son William O. Bowers 1123 Moller Avenue Hagerstown, Maryland 21740 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from State Smithsburg Crematory 7/24/00 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Neme end Address of Fecility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland respiretory errest, Appro 21740 Pert1. Enter the disease, or complications that caused the weth. Do not enter the mode of dying, such as cardiac or respirations, or heart feilure. List only one cause on each line. Physician liovasula disão yeas. /Medical immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. Physician/Medical Due to (or es e consequence of): usa Ö P.O. Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy periormed? Completed certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) 1 ☐ Yes 💥 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of injury (Month, Dey Year) 27. Menner of Death To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? After Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner steted. 29a. Certifier Medical 29b. Signature and title of our 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

30. Name end eddress of person who completed entise of deeth (Item 23e) (Type, Print)

M. D.

32. Registrer's Signature

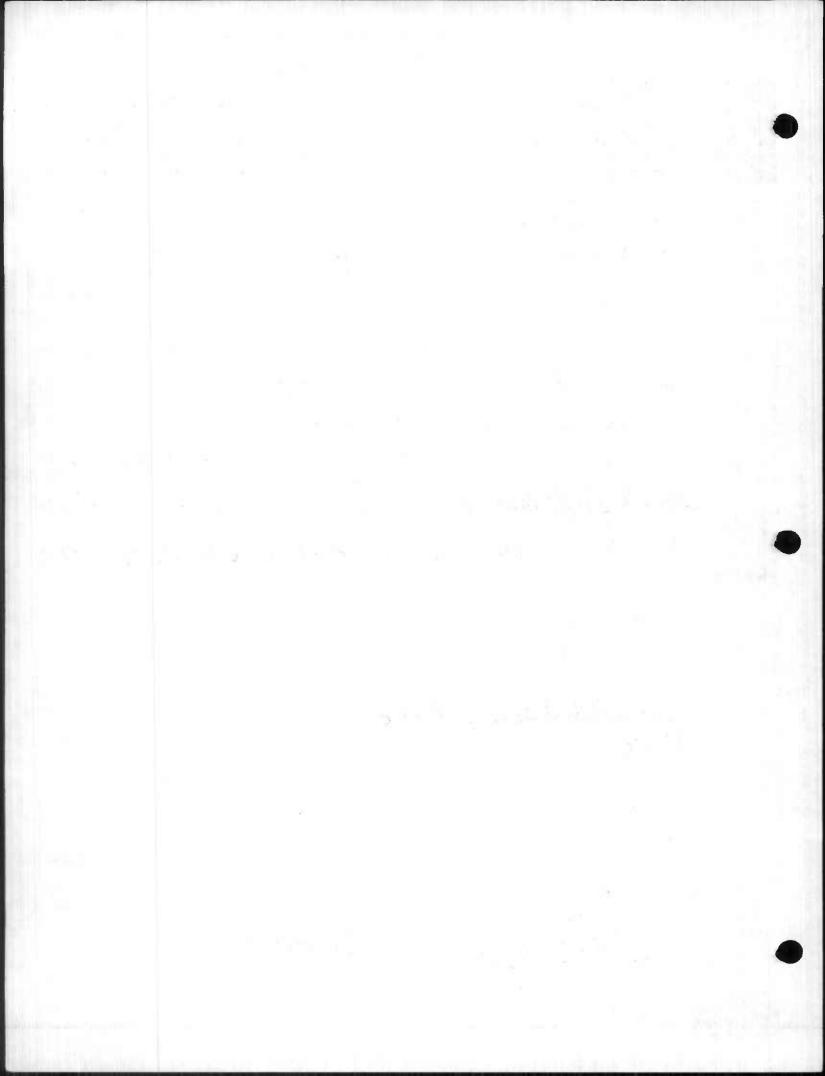
747

Northern Avenue Hagerstown, Md.

souls

Allen W. Ditto,

31. Dete filed (Month, Dex Year) 2000



3. TIME OF DEATH

Pennsylvania

10d. INSIDE CITY

1 YES 2 X NO

8. BIRTNPLACE (State or Foreign

8:05 p. M

REG. NO.

2000

1908

9c. COUNTY OF DEATN

Washington

10g. CITIZEN OF WHAT COUNTRY?

USA

her own home

14. RACE — American Indian, Black, White, atc.

white

Approximate intarvai Between

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE

1 | YES 2 | NO

DF DEATH?

29d. DATE SIGNED/(Month, Qay, Year)

Onset and Death

110

2. DATE OF DEATH

July 17,

7. DATE OF BIRTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

219-20-1007

Perle Lorraine BOWLING

1 M 2 X F

	deal
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	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
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	SPITAL

Dec. 14, should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 1150 Rose Hill Avenue Ext. DIRECTOR Hagerstown Pages 1, 2, 3 RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Washington Hagerstown permit. 10. STREET AND NUMBER FUNERAL 10f. ZIP CODE 1150 Rose Hill Avenue Ext. burial-transit 21740 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 K NO Specify: BY 3 🗶 Widowed 4 🗌 Divorced funeral director, page 5 should be detached for use as the ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) COMPL Homemaker 0 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jerimiah J. Spence 7 Ruth Jane Stoops notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Harrison - daughter 1150 Rose Hill Ave., Ext., Hagerstown, Md. 21740 must be 20e, METNOD OF DISPOSITION

1 X Buriel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE St. Mary s Carholic Cem. 7-21-00 Fairfield, Penna. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF JUNETIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 in by the 1 or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallura. List only one cause on each line. 0 filled **IMMEDIATE CAUSE (Final** cremation, the Ssophagea disease or condition resulting in death) completely event, OR AS A CONSEQUENCE OF and com traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If any, leading to immediate cause. Enter UNDERLYING physician prior other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): the attending p that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY an of any signed Health 1 TYES 2 NO Shows has be Dept. 4 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) the State I Item HOSPITAL: OTHER: TO YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED offer this ce eath with the marked, 1 Natural
2 Accident 5 Pending investigation 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY 26s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29s. CERTIFIER 1 1 💢 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILED WITHIN 72 M 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 238 May E 0 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary E. Money, 354 Mill Street, Hagerstown, Maryland 21740 31. DATE FILED (Month, Day, Year) JUL 2 0 2000 32. REGISTRAR'S SIGNATURE Geneva sacks!

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER I YEAR

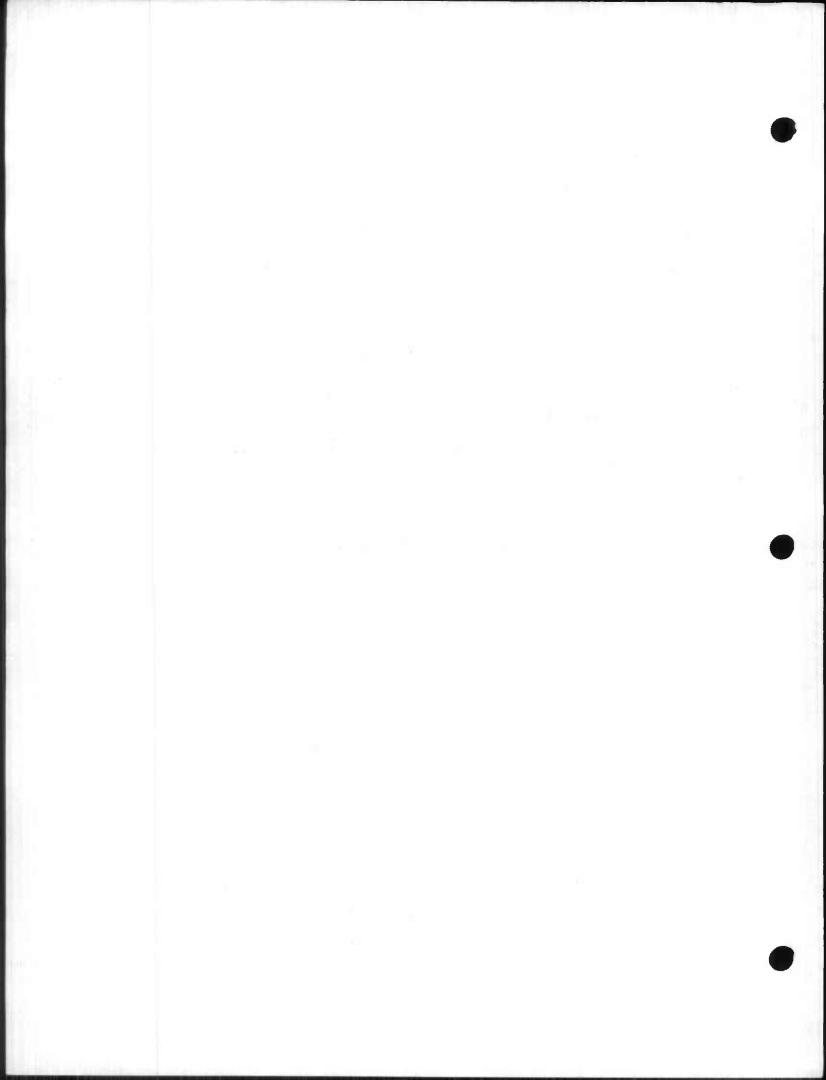
IF UNDER 24 HRS.

8. AGE (In yrs. last birthday)

YRS.

91

DHMH-16 Rev 1/89



Amended #2, NLS, 7/17/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yerry **Physician** Evelyn F. Cherry 2000 6:05PM 14 /Medical THE PLANE 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 722 Hilltop Drive Cumberland Allegany H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 28, 1911 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2♥F 213-09-7844 89 MD Director Usual Rasidance of Dacedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow then "natural", or frame 23s or 28s-f above the Medical Examiner must be notified at Yas 2 No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Hilltop Drive 21502 Funeral USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer in the red of Health and Mentel Hydiene. In the many 7 is merted other than "natural", or flaury or other traumatic avent, the Model Community or other traumatic avent, the Model. 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 □ Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Nema (First, Middle, Last) Be Roy E. Weller Fannie (NMN) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Husson-daughter 722 Hilltop Drive Cumberland MD 21502 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery 07/17 Hanover, PA 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Scarpelli Funeral Home, PA Cumberland, MD 23a. Pert1. Enter the disease, or complications thet/caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or each line. Approximete Intervel Between Onset end Death Physician Immediete Ceuse (Finet diseese or condition resulting in deeth) /Medical uk months Examiner Carcinomatosis Due to (or es e consequence of): Examine The lew requires that the death certificate be executed burial-transi Sequentially tist conditions, if any, feeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of): USB signed by the atter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably V Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, Completed by 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 s hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Wes casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospitet: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To Yes 2 No this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation e Hospital or Attanding 24 hours after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifies 29c. License number

my State

6

Deputy Medical Examiner

ss of person who completed cause of death (Item 23a) (Type, Print)

124 W. 3rd Street Cumberland MD 21502

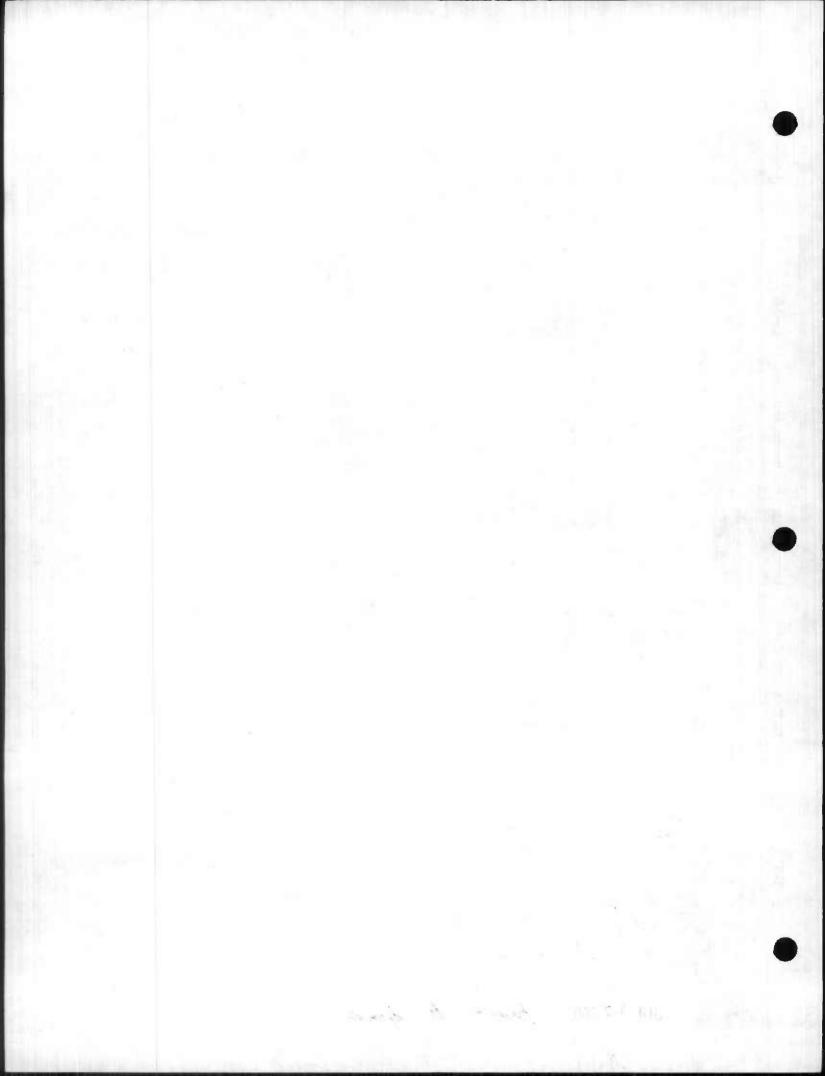
July 16, 2000

31. Data filed (Month, Day, Year)
JUL 17 2000 Registrar

Dr. Paul Snow

32. Registrar's Signature

D09157

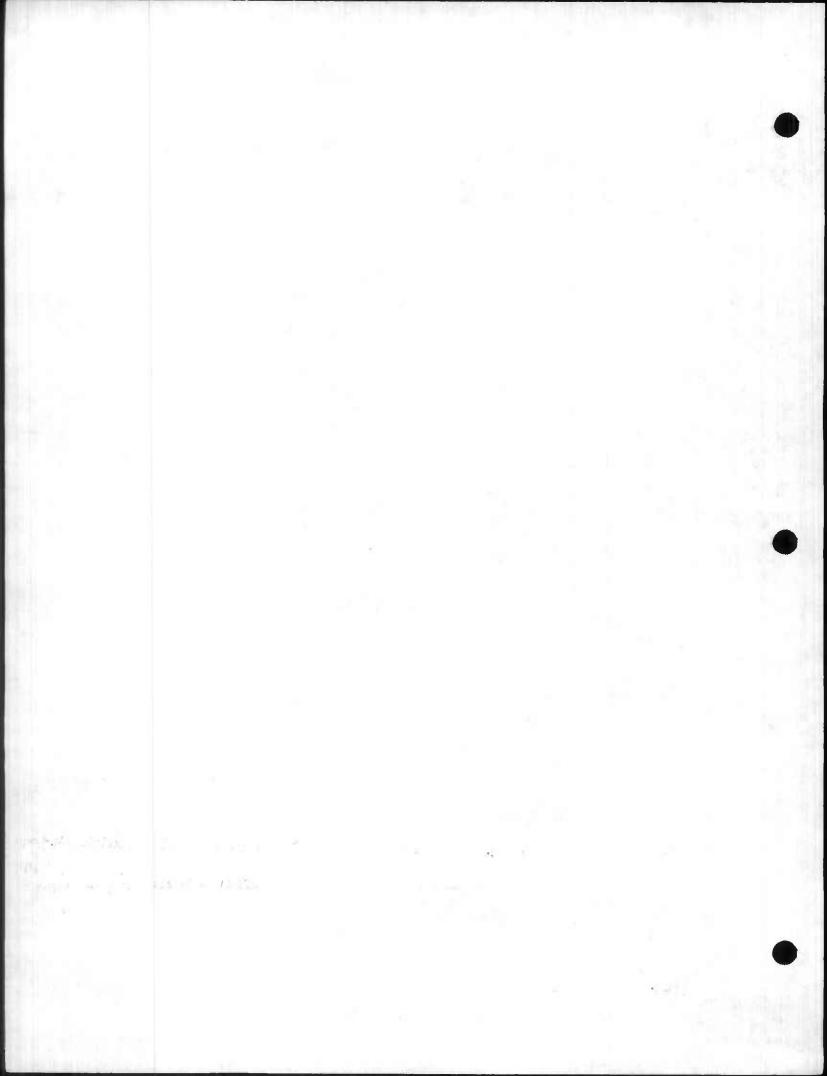


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 24809

						Cei	tificate	of i	Death			Reg. No.			
			1. Decedent's Neme (First, Middle, La	ist)							2. Date of De		Vasa	3. Tim	e of Death
	Physicia		JERRELL DWAY	NE CROW	DER						Month July	Day 14	2000	6:	00 P.M.
	/Medic Examin		4e Facility Neme (If not institution, give						4b. City, To	wn, or Lo	ocation of Deeth		ounty of Deeth	_	00 1 1111
	Examin	eı	Route 63 North			ing Ro	he		Hager	etor	70	TAJ =	ashing	ton	
_				Sex	7. Aga (In yrs.		If Under 1	1	If Undar		8. Date of Birt		and and		ate or Foreign
	Funeral			1 XM 2 □ F	37	Yrs.		Deys	Hours	Min.	(Month, De	y, Year)	Cot	VIRG	
	Director		Usuel Rasidence of Decedent		37						1/16/1	963	MEST	VING	INIA
	pue M		10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	e City Limits
	e ho	5	WV BERKE	IEV		PO BO	X 295	. F	A L.I.TN	IG W	TERS			101	Yas 2 No
	Ne Ne	ect.		1151		10 00						10- 011	4 Mile -1 Co		
	filed within 72 hours after deeth with the Meryland Hygiene. Wher than "netural", or flarme 23a or 28a-f show ent, the Medical Exercises must be notified a	Director	10a. Street and Number				10f. Zip C						n of Whet Co	untry r	
	23°	by Funeral	PO BOX 295		A Later			254					USA		
	ep L	- P	11. Maritel Stetus	12. Was Dec	edent Evar in U, orcas?	,S. 13. \	Wes Deceder f Yes, specify	nt of H y Cube	lispanic Ori en, Mexican	gin? (Sp , Puarto	ecify Yas or No Rican, etc.)	- 14.	Black, White		1,
0	or it	E	1 Nevar Merried 2 Married	1 ☐ Yes If Yes, G	2 No		1□Yes 20	X No	Specify:			Sr	pecify:	WHITE	
9	ours Fel.		3 ☐ Widowed 4 ☑ Divorced	Year or I									roony.		
21215-0020	72 h	Be Completed	15. Decedent's E (Specify only highest gro			16a. Deced	dent's Usuel I kind of work	Occup	ation	of work	ina	16b. Kind	of Business/I	ndustry	
7	thin thin	5	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT use	retired	3)						
2	d with giene. rr ther	0	12			T	RUCK D	RIV	/ER			SEAL	Y MATT	RESS	CO.
B	other other	9	17. Father's Neme (First, Middle, Last)					18. Mothe	r's Nem	a (First, Middle,	Maiden Su	ımeme)		
Maryland	Mental Merital arked o	TOE	JERRELL WAY	NE CROW	DER				ME	ELOD.	EICHE	LBERGI	ER		
2	should be and Mental s marked o numatic sv		19e. Informent's Neme/Reletionship	Type, Print)	203	19b. Mailir	ng Address (Street	end Numbe	or or Run	al Route Numb	er, City or T	own, Stete, 2	(ip Code)	
Ž	end 2 saith e n 27 is		JERRELL W. CROW	DER / F	ATHER	484	EMERS	ON	DR.,	FALL	ING WAT	ERS,	WV 254	19	
é	Hea		20a. Method of Disposition		20b. P	Plece of Dispo	sition (Neme	of		T	Data	20c. Local	tion - City or 7	Town, Stet	a
٥	Pages nent of int: If Its iny or o		1 Burial 2 ☐ Cremetion 3 ☐		Stete	emetery, crer				1	7/10/00	MADE	TMODED	0 1111	
Ë	trant Jury		4 □ Donetion 5 □ Other (Speci		R	OSEDAL					7/19/00			G, WV	
Baltimore,	permit. Peges 1 and 2 should be filed within Department of Health and Mohelal Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the sente.		21. Signature of Funeral Service Lice			B ²	ROWN F	Addre	SS OF ESCILIT	OME	327 W	. KING	G ST.,		
_	202 = 8		Charles m	. Bro	run						SBURG,				
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that	caused the deat	h. Do not ent	er the mode	of dyir	ng, such es	cardiac	or raspiretory e	rrest,		Approxi	imete Between
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	eath certificate be executed attending physician and for use es the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (d	or as a consec	juence of):								
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Bo	ath c then or us	an							0				1		
	that the death come by the attended for us	Physician	Pert II. Other eignificant conditions	contributing to c	death but not res	ulting in the u	nderlying cau	use giv	en in Pert I		23b. Dld	tobacco us	e contribute	to the cau	use of death?
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Viita	Physician: The risk certificate sral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or:		h (Check only				
ō	this all di	To	1 XYes 2 No	1 1 1		ER/Outpatier		,	4 1140	ırsing Ho	me 5 Resi		Other (Spec	cify) at	scene
	After funer	0	27. Manner of Death 1 □ Naturel 5 □ Pending	28a. Dete (Moi	nth, Day Year)	28b. Time of Injury	11	c. tnjui Woi		/	28d. Describe			·icio	untered per
000	ttendi deeth. stor: A	at	2 Accident investigation		14-00	16:41	М		Yes 2	No	lotoely c	CF DEA	new pool	1017100	mpky 666
Division	after deet Director:	#	3 Suicide 6 Could not be detarmined	28e. Plec	a of Injury - At he ling, etc. (Specif	ome, ferm, str	eet, factory,	office			28f. Location (City or To	Street and I wn, Stete)	Number or Ru	ure/ Route	Number, HC
<u> </u>	al Direction bed in b	Certification:			RODO	husy				Ø	2T63 WW	+ Broom	FORDIN	L WASH	HUCHOU G
	hour hour hy fill	la l	29e. Certifier 1☐ Certifying PI								end due to the	cause(s) er	nd menner es	steted.	
	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examone)		ner steted.	tion end/or in	vestigation, ii	n my c	pinion, dea	th occur	red at the time,	date and pi	lece, and due	to the cau	se(s)
	vithir omp	2	29b. Signature end title of certifier	Α.	9.111.1	10107	29c.		a number			29d. Date	signed (Monti	h, Day, Ye	ar)
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			30. Nema end address of person who						8			JI D			
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	Šta		31. Data filed (Month, Day, Year)	2000	Registrer's Signa	A L	1 de	oan	Kr						
	Registra	dl	SOL N I			1	16								

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Winifred Madeline DeHaven 0519 101 2000 Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) July 7, 19 7. Aga (In yrs. last birthday) Birthplece (State or Foraign Country) **Funeral** 1□M 2☑F Days Hours 76 Yrs. Virginia 229-16-9786 Director Usual Rasidance of Dacedani the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 20009 Rosebank Way 21742 USA natural', or Items 23s. Funeral 12. Wes Decadant Evar in U,S. Armed Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Mental Status 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2₺ No Specify: Specify: P 3 ☐ Widowed 4 ☑ Divorced white Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry filed within 7 Hygiena. Office of Consumer Elementary/Secondery (0-12) College (1-4or 5+) 0 program director Advocacy other permit. Pages 1 end 2 should be fits Department of Heath and Mentel Hy Important: If Item 27 is marked oths any Injury or other traumatic event, phos. 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Clifton Wilson Mable Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Carol K. Mertz - daughter 20107 Kelly's Lane, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cematary, cramatory or other pleca) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Ramoval from Stata 7+19-00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 22. Nama and Addrass of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immadiata Cause (Finel disaasa or condition rasulting in death) /Medical Pulmonary Embolism Examiner Dua to (or as a consequence of). Examine 1-2 4rs (Chronic endstage emphysema Sequentially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Diseese or Injury that initieted evants rasulting in death) Last pue attending physician addiction > 40 yrs P.O. Box 68760 nicotine Physician/Medical Dua to (or as a consequence of): as t Dehoven, Wini Fred tound Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 Unknown insufficiency Chronic renal Division of Vital Records. p 24b. Wara autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy Completed Advanced Coronary Disease After this certificate has page 1 Yas 2 No 1 ☐ Yas 2 No Be 25. Was casa rafarred to medice! 26. Place of Death (Check only ona) axaminar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 10 1 Yas 2 No 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Panding investigation 1 ☐ Yas 2 ☐ No death. 2 Accidant after death 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida 0 To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Phyelcfan: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) tiple of ceptilies 29b. Signetur

State Registrar 19236

30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

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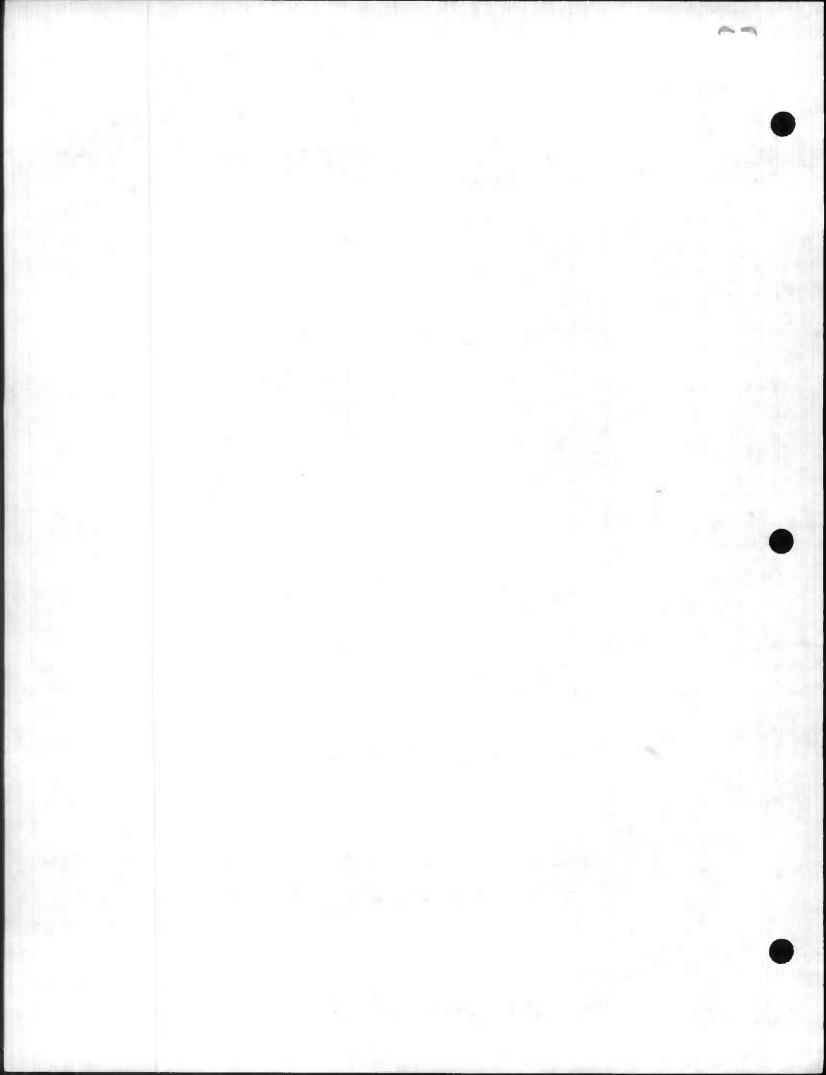
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2000³². Ragistrars Signature

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JULY 14,2000

MEADON VIEW DR, HAFBERSONW MD 21742



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No.

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					Cel	uncate	9 01	Dealn			Reg.	No.		- 1011
	Physician /Medical	Decedent's Name (First, Middle, AMELIA ELIZABE		ſΑ						2. Date of De Month	2	Day 25 200	Yeer OO	3. Time of Death 1:35 PM
	Examiner	4a Facility Name (If not institution,	give street and nun	nber)						ocation of Deat	h	4c. County	of Death	
		SACRED HEART H						CUMBI					EGANY	
ı	Funeral Director	216 01 8818	6. Sex 1 ☐ M 2ŽÖ F	7. Age (In yrs. la 87	st birthday) Yrs.	if Under Months	Days	If Under Hours	Min.	6. Date of Bir (Month, Di SEPT 1	th ay. Ye 7 1	912		plece (Stete or Foreign http:) YLAND
	p a	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation	-		-				1	I Od. Inside City Limits
	aho a													1 ☐ Yes 2 No
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	er death with the Maryland theme 23e or 28e-f show ner must be notified at uneral Director	D. T. D. O. M.C.	A NIMOLTNI								iog.		Wilat Cool	my r
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		11. Marital Status 1 ☐Never Merried 2 ☐ Marrie	Armed Fo	rces?		If Yes, speci	fy Cub	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)			ck, White,	
20	0 0		If Yes, Giv Year or Do	0		1□ Yes 2	No D	Specify.				Specify	v: W	HITE
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bu	tai Hy doth		ast)					18. Moth	er's Nam	e (First, Middle	, Maio	den Suman	ne)	
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Maryland	nd 2 sh sith and 27 Is m r traum	19a. Informent's Neme/Relationsh PAUL FIORITA / E								BURG, M			Stata, Zip	Code)
ore,		20a. Method of Disposition		cor	ce of Dispo	sition (Nem	e of her pla	ce)		Date	200	. Location	City or To	own, Stata
altimore		1 ☐ Burial 2√√Cremation 4 ☐ Donation 5 ☐ Other (Sp	a Li Hemoval from :	State					RY 7	/26/00	CU	JMBERI	LAND,	MD
alti	permit. Pege Department of Important: If any Injury or once.	21. Signature of Funeral September Licenses 22. Name and Address of Facility												
m	88 E E 8	SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532									32			
Г		23a. Pert1. Enter the disease, or o shock, or heart failure. List of	complications that c	aused the death.									1	Approximete Interval Between
	Physician	orion, or riour families.	-		0.0		1 -	-						Onset and Death
	/Medical	immediete Ceuse (Final disease or condition		KESPI	1 RA	TOK	1	111	414	-UKE	_			5DAYS
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	certificate be executed ding physicien and se as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or	as a consec	quence of):	10	770		D158	7/	102	- 1	DYFAD
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n	After the funera		28a. Date (Mont	of Injury th, Day Year)	28b. Time o Injury		Bc. Inju Wo			28d. Describe	how	injury occui	rred	
Sio	Attending or death. ector: After by the fune	2 Accident investig	etion			М	1 🗆	Yes 2	No					
Division	ral or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could n 4 Homicida datamii	ned 20a. Flace	of Injury - At honing, atc. (Specify)	na, farm, str	reat, factory,	, office		5	28f. Location City or To	(Stree wn, S	it end Numi itata)	ber or Rur	rel Route Number,
	oral Delined		me states To a				4 41 - 11		4 -1			- /- \ 4		-1-1-4
	n 24 hound n 24 hound	29a. Certifier (Check only one) 1 Certifying 1 Medicai	Physician: To the examiner: On the be											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29b. Signature and little of certifier	4.0		0	29c.	Licens	se number			29d.	Date signs	ed (Month,	, Day, Year)
	+ 3 + 0 2	1/hans	Myst	mo	4		1	24	95	-1		JULY .	25	2000
		30. Name and address of person w	the completed cause	e of death (Itam :	23a) (Type	Print)	- 2	- 1	1)			OUL!		2000
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Registrar

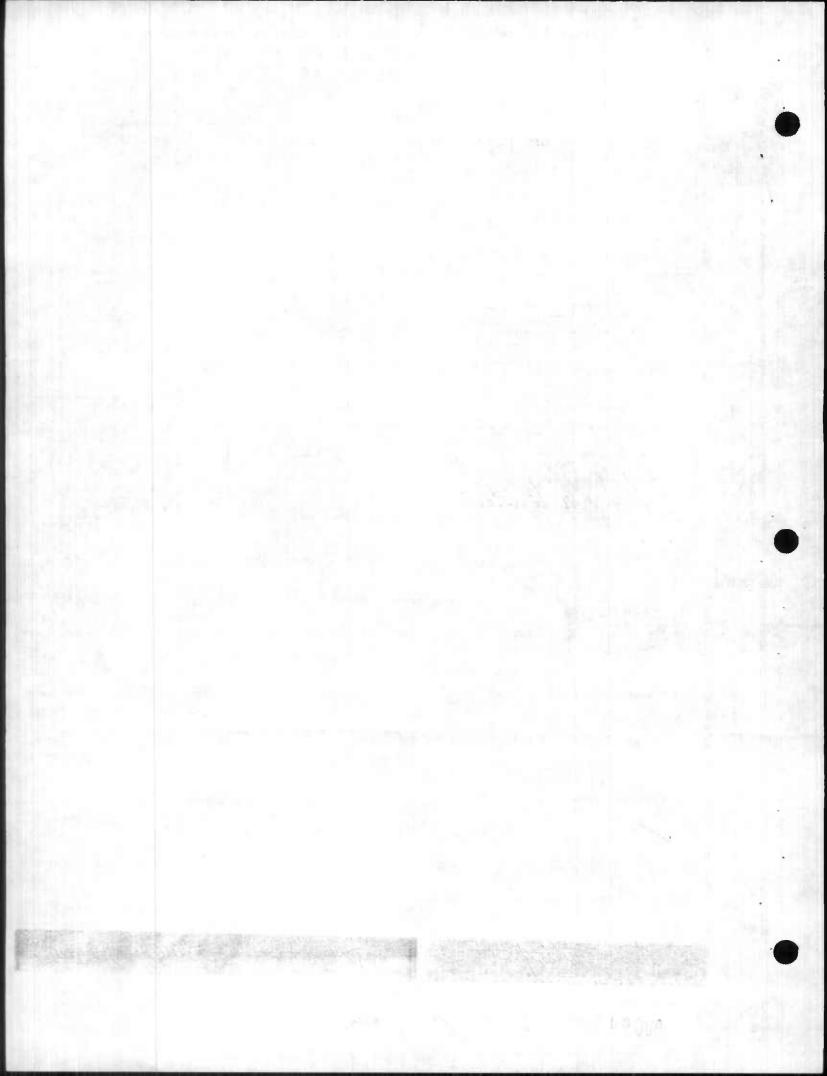
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State of Maryland / Department of Health and Mental Hygiene

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			Certifi	cate of Death	F	Reg. No.	24012
	1. Decedent'a Nama (First, Middla, Las	st)		E DE LE	2. Data of Dea Month		3. Tima of Death
Physician /Medical	Margaret Mar	ry Freed			July	27, 200	8:50 AM
Examiner	4a Facility Neme (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		
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Funeral Director	5. Sociel Security Number 6. S 199-14-0018 1	ex 7. Age (In yrs		Inder 1 Year If Under 24 Hrs onths Days Hours Min.	(Month, Day	, Yaar) 1924 Pe	Birthplaca (Stata or Foraign Country) ennsylvania
v	Usuel Residence of Decedent						
how	10a. Stata 10b. County		City, Town or Location				10d. Inside City Limits
h the Merylen r 2844 show Incirited at	MD Baltim	nore	Towson				1 □ Yas 2 No
fm into the Menyland into them 23a or 28a-f show them 23a or 28a-f show the must be notified at the most be not the contract of the contract between the most benefit at the most benefit at the most benefit at the contract	10e. Street and Number 2 Southerly Co	ourt	10	f. Zip Code 21286		U.S.A	
	11. Marital Status	12. Was Decedent Evar in Armed Forces?	U,S. 13. Wes I	Decedent of Hispanic Orlgin? (S apecify Cuban, Maxican, Puer	pecify Yaa or No-	14. Race -	American indian, Whita, atc.
by 15.	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Datas:		as 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	White
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/Medical	Immediata Causa (Final disaasa or condition	Muelo	den das	tic Syndra	ne		5 yrs
Examiner	rasulting in death)	a. U Dua to	(of as a consequance	e of):	, - 0		
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After funer	1 Matural 5 Pending	28a. Data of Injury (Month, Day Year)	Injury	28c. Injury at Work?	200. Describe II	low injury occurred	
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Division of Vital Records, P.O. Box To the Hospital or Attending Physicien: The law requires that the death cert within 24 hours death death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use. Medical Certification: To Be Completed by Physician/M	29a. Cartifier 1- Certifying Ph	viner: On the basis of axamir	nowladga, daath occi nation and/or invastig	arred at tha time, date and plece ation, in my opinion, daath occ	e, and dua to tha curred at tha tima,	causa(s) and manr data and placa, an	ner as stated. d due to the cause(s)
ithin the mple	29b. Signature and titla of certifier	and mannar stated.		29c. Licansa number		29d. Date signed /	Month, Day, Year)
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State Registrar	AUG 0 4 2000	Lendra	& loo	16:			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 26 2000 **Physician** 4:40P.M. Melvin Lee Gilroy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner LA PLATA CIVISTA MEDICAL CENTER CHARLES | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 7 - 1 0 - 1 9 2 9 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 20 F 71 Maryland Director <u>215-26-0672</u> permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natural", or itema 23s or 28s-f show withingtor or other traumatic avant, the Medical Examinar must be notified at each about. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? 20662 United States 9340 Ironsides Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∜☐ No If Yes, Give⁷ Year or Dates: 14. Raca - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specity: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electrical Elementary/Secondary (0-12) College (1-4or 5+) Contractor Electrician 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 2 Minnie M. Johnson Bernard M. Gilrov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 6 6 2 19a. Informant's Name/Relationship (Type, Print) Emma L. Gilroy/Wife 9340 Ironsides Road, Nanjemoy, Maryland 07-29. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1) Qurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Trinity Memorial Gardens 2000 Waldorf, Maryland 22. Name and Address of Facility 21. Signeture of Funeral Service Licenses 20640 Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, INdian Head, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failurg. List only one cause on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner g physician and as the budal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated seep or injury) Due to (or as a consequence of): 68760 Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of) Box 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probebly 4 Unknown Discerse OBSTRUCTIVE Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; s 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: 1 Diletural 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide tire certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contified D-44436 26 2000 own 8 ss of person who completed cause of death (Item 23a) (Type, Print) PATEL M.D. 6 INDUSTRIAL PARK DRIVE WALDORF MARYLAND 20601 ASHVINKUMAR J.

DHMH 16 Rev 6/95

State

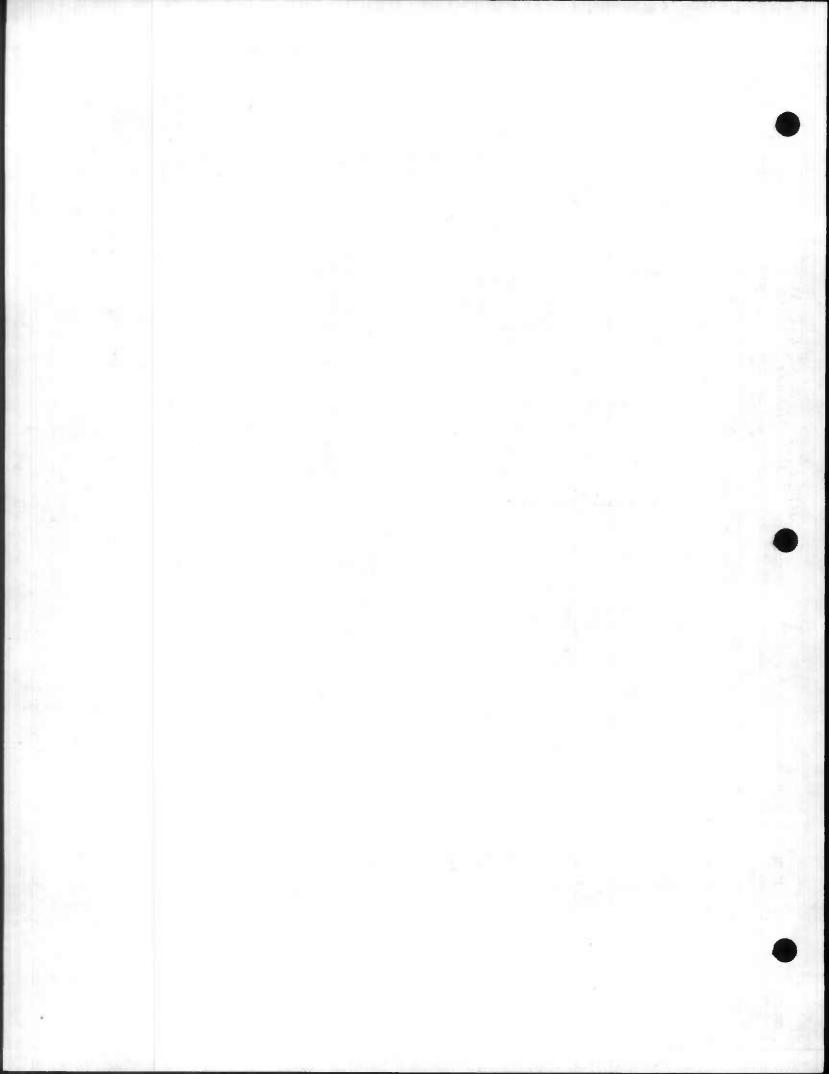
Registrar

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

Deper



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State of Maryland / Department of Health and Mental Hygiene

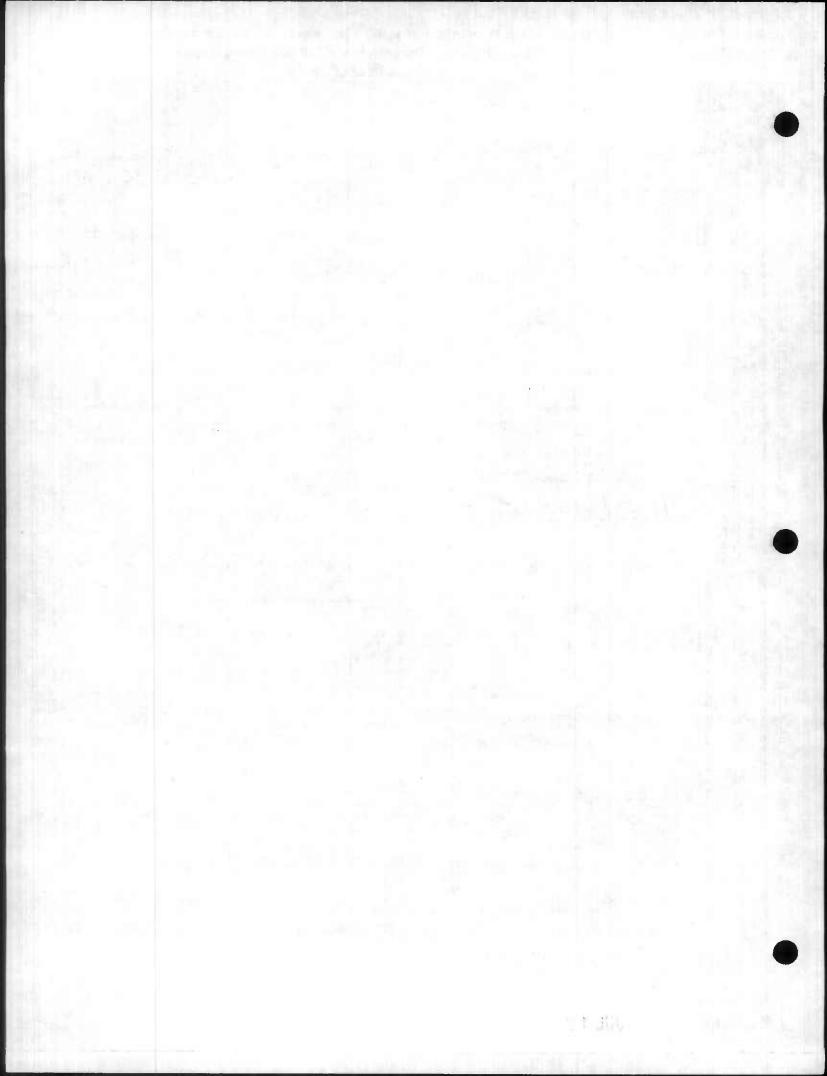
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	Cen	tificate of Death	Reg. No.	Cm 9019
	1. Decedent's Name (First, Middla, Last)	2	. Date of Death	3. Tima of Death
Physician	SAMUEL CLARK HARRISON, SR.		July 17 20	1602
/Medica Examine	4e Facility Neme (If not institution, giva street and number)	4b. City, Town, or Local		CAC-MA
Examine	The Memorial Hagnital	Factor	Talbot	
Funeral	The Memorial Hospital 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday)	Easton If Under 1 Yaer If Under 24 Hrs. 8		Birthplace (Stata or Foreign Country)
Director	213-18-5086 1X M 2DF 83 Yrs.	Months Deys Hours Min.	(Month, Day, Year) EB. 13, 1917	Country) MARYLAND
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OS per people should			performed?	available prior to completion of cause
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	30. Nama and address of person who completed causa of death (ttam 23e) (Type, F	Print)	1110	100
	CAROLYN HELMLY, M.D., 606 DUTCHMAN'S	· ·	21601	
-04-1	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	ZIZIZI ZIZIZI FID Z	-2001	
State Registrar		1. 1.		
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DHMH 16 Rev 6/95

Samuel Harrison

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State of Maryland / Department of Health and Mental Hygiene

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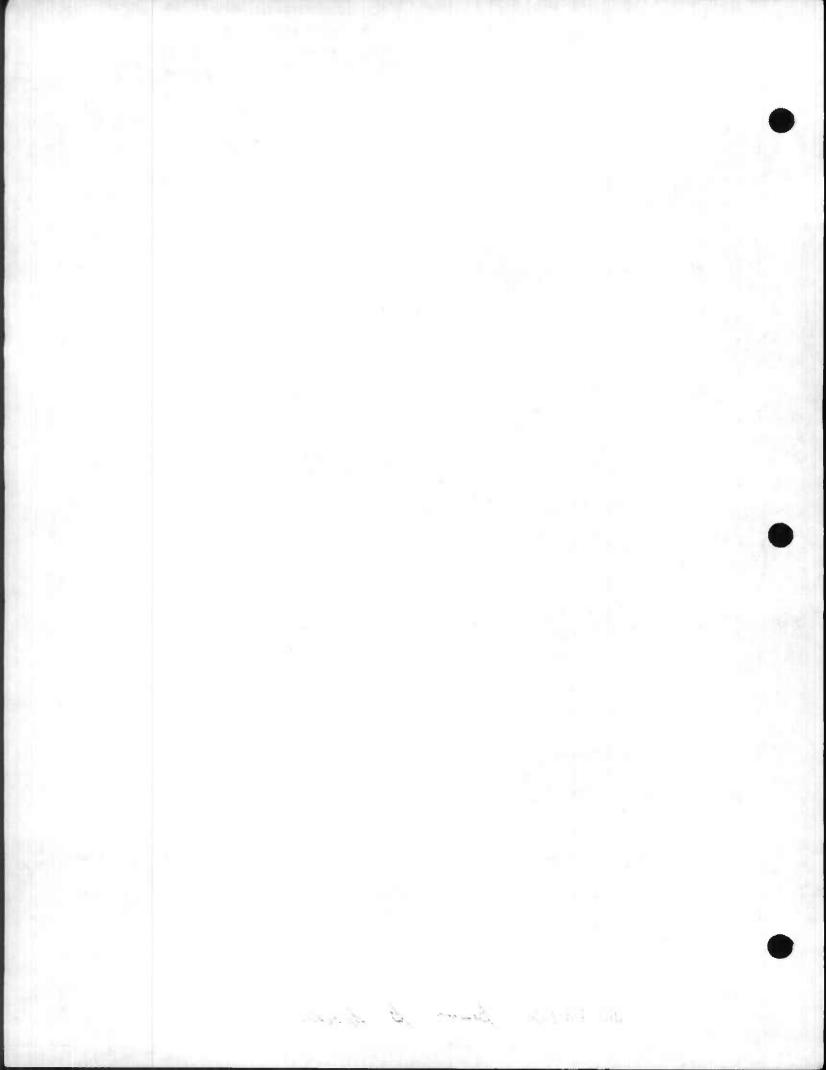
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DHMH 16 Rev 6/95

JUL 13 2000

State Registrar



Amended, #25, NLS, Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

7/19/00, AI	legany Co.	•	epartment of Health and Certificate of Death		giene (00 24817
	1. Decedent's Neme (First, Middle, Last,			2. Dete of De	eth	3. Time of Death
	Louise J.	. Hei:	nrich	Month JULY	Dey 15 2(Year 000 12:15 PM
/Medica Examine	An English Mama Hand Institution when	street and number)	4b. City, Town, o	Location of Deet		
Examine	Memorial Hospital	& Medical Center	Cumber1a	and	Allega	anv
Funeral Director	5. Social Security Number 6. Sec	7. Age (In yrs. last birth		s. 8. Dete of Bir	th Year 908	Birthplece (State or Foreign County)
with the Meryland a or 28a-f ahow Les notified at	10e. State 10b. County	any 10c. City, Town	or Location umberland			10d. Inside City Limits 1 1 Yes 2 □ No
th with the Me 23e or 28e-fa	10e. Street and Number 12916 N. Cresap	Street NE Apt	. 5 101. Zip Code 21502		10g. Citizen of W USA	/hat Country?
5-0020 72 hours effer death v	3 Widowed 4 □ Divorced	12. Wes Decedent Ever in U,S. Armed For \$\frac{\delta}{\delta}\sigma^2\cdot 2 \rightarrow No 1\ Yes, Give Yeer or Detes:	13. Was Decedent of Hispenic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 【☐ No Specify:	Specify Yes or No rto Rican, etc.)	Bleck	e-American Indien, k, White, etc. white
within within the Men	15. Decedent's Edu (Specify only highest grad	College (1-4or5+) For	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) MEX Employee L Proparation	orking	16b. Kind of Bu	siness/industry pringfield
Viand 2 Wental Hyginarked other	Frederick Feller			eme (First, Middle (Kuhlr		9)
CENE	Elfa-Lingormani's Napa/Ralanjopship (Ty daughter	rpe, Print) 651°-	Mailip Address (Street and Number of the	Jural Route Numb	"MD "217	State, Zip Code)
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Baltimore, permit. Peges 1 er Department of Her Important: If Ham: any Injury or other	21. Signeture of Funeral Service Licens		Scarpeldisofuner Cumberland, MD	al Home		
Physician	23e Part1. Enter the diseese, or complishock, or heert feilure. List only of	cations that caused the death. Do note cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory a	rrest,	Approximate Intervel Between Onset end Deeth
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	Aspiration pneu				2 days
		Hip fracture				2 days
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687 ficate phys is the	resulting in death) Lest	Due to (or es a co	onsequenca of):	\cap	1	
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ew requires been 2 should				24a. Wes	en eutopsy ormed?	24b. Were eutopsy findings evailable prior to completion of ceuse of deeth?
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Division C pital or Attending P ours after death. weal Director: Affert filled in by the funers	3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (City or To	(Street end Numb wn, Stete)	er or Rurel Route Number,
he Hospi in 24 hou he Funer pletely fill	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination		deeth occurred et the time, dete end pla /or investigation, in my opinion, deeth oc		date end plece, e	end due to the cause(s)
To the Total	E 29b. Signature and title of certifier		29c. License number		29d. Date signed	(Month, Day, Year)
3	1/4		D36766		JULY 17	2000

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Registrar

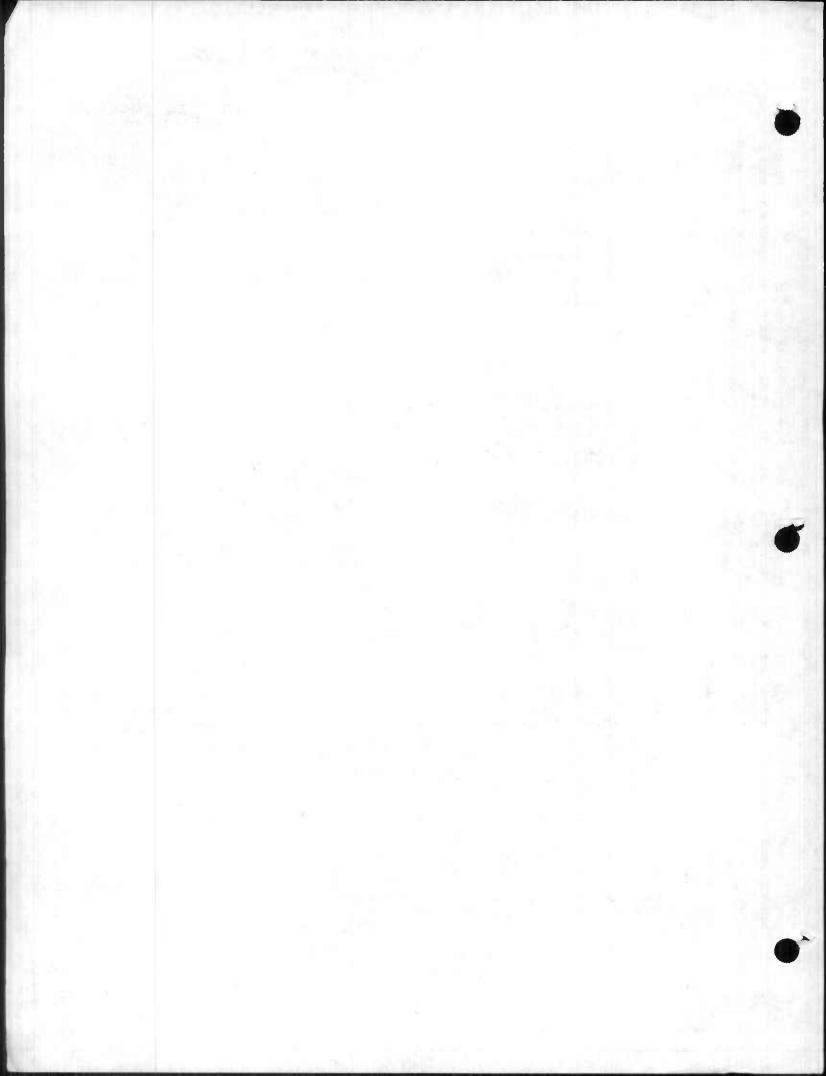
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. V. Poonai, 920 National Highway, LaVale, MD 21502

in a on the second

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death	F	Reg. No.	UU	24818
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į,	Physiciai /Medica		Terry E. Jo	nes					07	20	2000	10'00 M
	Examine	-	4a Facility Name (If not institution, give s					4b. City, Town, or L	ocation of Death	4c. Co	unty of Death	
			Chesapeake Woods					Cambridge		- 1	chester	
	Funeral		5. Social Security Number 6. Sex	M OFF	(In yrs. last bi	Yrs. If Unde		r If Under 24 Hrs. s Hours Min.	(Month, Day	(, Year)	9. Birthpi Coun	lece (State or Foreign try)
	Director		215-84-8104 X Usual Residence of Decedent	335	y 4mo	113.			3/7/67		USA	
	dand ow		10e. State 10b. County		10c. City, Tow	n or Location					11	Od. Inside City Limits
	Many First	0	MD Dorche	ster	Camb	ridge						1 ☐Yes 2 ☐ No
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pu	正工专员 ,	e a	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sui	mame)	TO STATE OF THE PARTY OF THE PA
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		-	30. Name and addr of person who co	mpleted cause of de	eath (Item 23e)	(Type Print)		1-10		1	1	211-13
			0045-17-4000 +	+ ma Ho	a 0 m	am Han	14	57/2-1	1 muin	ST.	Braha	· 263
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month Physician Mary Frances Johns July 15 2000 4:30pm /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Westminster 3090 Nicodemus Road Carroll H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Yes Director 219-22-0312 Feb 10 1921 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits worle ! , or items 23s or 28s-f show 1 Yas 2 No MD Carroll Westminster Directo 10f Zip Code 10a. Citizen of What Country? 10e Street and Number 3090 Nicodemus Road USA deeth 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2K No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. other then 'r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if flem 27 is merked other that eny injury or other traumatic event, that page. 10 Homemaker Own Home 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) 8 Forrest Clyde Williams Sr Pearl Boggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3090 Nicodemus Road Westminster, MD 21
and Disposition (Name of Date 20c Location - City or Town, State MD 21157 Juan Johns/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial Pk 7/19 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Nama and Address of Facility ture of Funeral Service Licensee Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final . Atheroscherotic Cardiovas cular day disease or condition resulting in death) Examiner Diobetes Mellitus physicien end s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 6 besity Physician/Medical Dua to (or as a consequence of): 189 Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Renal insufficiency 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? peeu 1 Yes 2 No 1∏Yas 2∏No certificate Hospital or Attanding Physician:
 24 hours after deeth.
 Funeral Director: After this certifical letsiy filled in by the funeral director, Be 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Alesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide DEFCertifying Physician: To the best of my knowledge, death occurred at the tima, data end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the F 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifie DO052815 17/2000 alexande 30. Nama and address of pegson who completed cause of death (Item 23a) (Type, Print) ode Ra Westminster MB 21159 68600 Alexander 31. Data filed (Month, Day, Year) 32. JUL 1 9 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24820 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath **Physiclan** Month **JOHNSON** 18 NELLIE V. JULY 2000 2:55 PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 20160 BROWNSVILLE ROAD KNOXVILLE WASHINGTON If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. lest birthday) If Under 1 Yaar 5. Social Sacurity Number Birthplaca (Stete or Foreign Country) **Funeral** Days 1□M 2XF Yrs. Director 82 212-20-5803 MARCH 7, 1918 MARYLAND Usual Residanca of Dacedant the Maryland to or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yas 2 X No MARYLAND WASHINGTON KNOXVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? *natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Haaith end Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, The Medical Examiner press. Once. 21758 20160 BROWNSVILLE ROAD Funeral U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Datas: Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarlcan Indian, Black, White, etc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 ☒ No Specify: Completed by 3 ₩ Widowed 4 Divorced Specify: WHITE 15. Decedant's Education (Specify only highest grede completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be WILLIAM S. APPLEBY NELLIE (UMN) MOORE 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20160 BROWNSVILLE ROAD, KNOXVILLE, MARYLAND 21758 SHARON M. DALY/DAUGHTER 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) SMITHSBURG CREMATORY 7/22/00 SMITHSBURG, MARYLAND 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility 7606 Old national Pike BAST FUNERAL HOME Boonsboro, Maryland 21713 To the Mospital or Attending Physician: The law requires that the death certificeta be assecuted within 24 hours eigher death.

To the Funeral Director. After this certificate has been signed by the ettanding physician and complately filled in by the Inneral director, page 2 should be datached for usa as the bunial-transit

Physician /Medical Examine

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

23a, Part1. Enter tha disaase, or comp shock, or haart fallura. List only o	olications that caused the dea one causa on each line.	th. Do not antar the n	node of dying, such as cardie	ac or respiretory errast,	Approximeta Intervel Batween Onsat and Death
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MD 21702

State Registrar

30. Nama and address of parson who completed ceusa of death (Itam 23a) (Type, Print)

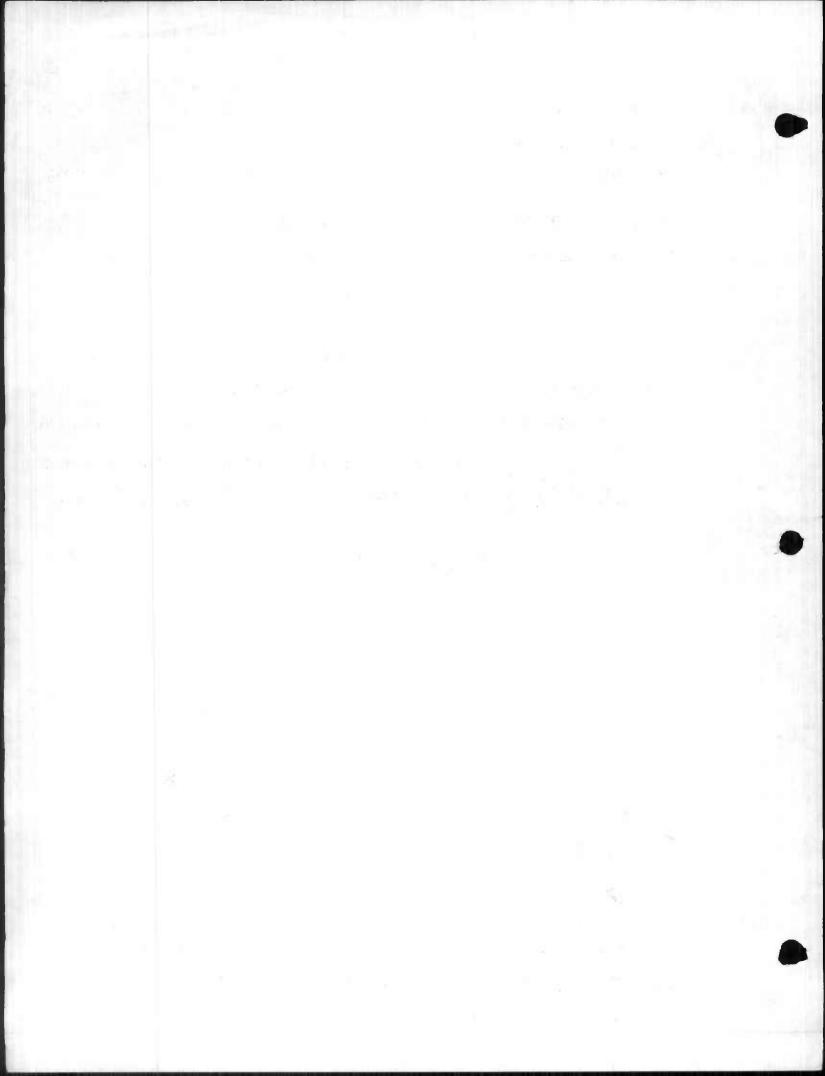
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2482 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month May 2000 31 22 50 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Cambridge Dorchester Dorchester General Hospital 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplaca (Stata or Foraign Country) Days 1 M 2□ F Yrs. 78 Sept. 16, 1921 Maryland 215-14-3128 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Cambridge Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 809 21613 Center Street 12. Was Decedent Evar in U.S. Armed Forcas? 1 Yas 2 □ No 2/43— If Yas, Giva 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 1/46 Yaar or Datas: **Black** 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Cotlega (1-4or 5+) R J Revnolds Assembly Worker 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Elsie Jews Herman Jenkins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 809 Center Street, Cambridge, Maryland 21613 Jearlen Victoria Jews / wife 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 6/5/2000 Maryland Veterans Cem. 4 ☐ Donation 5 ☐ Othar (Specify) Beulah, Maryland 21. Signature of Funaral Sarvica Licenses 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O.Box 1687, Easron, Maryland 21601 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immediate Causa (Final Mongly disaasa or conditior rasulting in daath) leek Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Ware autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yes 2 200 1 Yes 200

Physician /Medical Examiner

Physician

/Medical

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Physician/Medical Examiner sician and burial-transit physician s the burial signed by the attending be detached for use Completed by edical Certification: To Be this funeral After 24 hours after death.

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P.O. Box 68760,

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Division or Attanding

Hospital

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Placa of Death (Check only ona)

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30. Nama and addrags of person who c

Hospital: 1 Appatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

impleted causa of death (Item 23a) (Type, Print)

Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

27. Manner of Death 1) SNaturat 2 Accident

3 ☐ Suicida

4 Homicide

5 Panding Invastigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifian (Check only one)

★☆Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, and due to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifian

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29c. Licensa number

State

Registrar

an A41019 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 24822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Wanda Pearl Kenney July 16. 2000 9:50 a.m. /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Memorial Hospital Cumberland
If Under 24 Hrs. Allegany Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M XXF Vrs Director 218-16-2784 May 14. 1920 Indiana Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28s-f show pernit. Pages 1 and 2 should be flied within 72 hours after death with the Maryle Department of Heelth end Mental Hyglene. Important: if itsm 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic avant, the Hadical Examinations, to actified an onde. 1 ☐ Yes 2 XNo Director WV Mineral Ridgelev 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? Route 3 Box 349 USA Funeral 26753 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black White etc. 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Factory Work Celanese Corporation 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Carlton Rex Hershberger Lena (Graham) 19e. tntorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Okey W. Kenney--husband Route 3 Box 349; Ridgeley, WV 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 X Donetion 5 ☐ Other (Specify) WV Human Gift Registry 07/16 Morgantown, WV 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 itions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, cause on each line. 23a. Pert1. Enter the disease, or complete shock, or heert tailure. List enty one Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical Ventricular Fibrillation--Asystole 50 minutes Examiner Due to (or es e consequence of): Examiner Hypertensive Vascular Disease 5 years physicien and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of) P.O. Box 68760. Diabetes Mellitus > 5 years Physician/Medicai thet initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the pege 2 should be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes en autopsy performed? 280 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; p 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 PR/Outpatient 3 DOA 27. Manper of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturel 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Thomicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 16 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es steted. 29a. Certifier Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29b. Signeture d title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 6 D0042840 July 16, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Too Reed A. Erickson, M.D.; 600 Memorial Ave; Cumberland, MD 21502 31. Dete tiled (Month, Day, Year) 32. Registrer's Signature State JUL 2 0 2000 Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Sant Microsis Cemelery 26-Jul-00 Frosthura Micyland

Durst Funeral Home, 57 Frost Ave., Hosburg, MD 21532

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey 20 11:55 p.m. 2000 Hilda Rose KARKO July 4e Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Julia Manor Health Care Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days 1□ M 2X F Yrs. 84 1916 218-03-8793 June 14 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Sussex Bridgeville 10g. Citizen of Whet Country? 10f. Zip Code U.S.A. Box 108 19932 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify Specify 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Her own home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Lillian Pearl Jones Lewis Franklin Bullen, Sr. 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Hagerstown, Md. 21742 Mary Doty - Daughter 11923 Peacock Trail 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method ot Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Hagerstown Crematory 7/22/00 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Nama and Addrass of Facility Minnich Funeral Home sucu 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intarval Batween Onset end Deeth MGDLAVdets

Physician /Medical Examiner

attending physician and for use as the burial-transit

signed by t

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After t

To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

i Hygiene.

permit. Pages 1 end 2 should be filed wit Department of Heelth and Mentel Hygiens Important: If Item 27 ie marked other tha any injury or other traumatic event, the Industrial Pages.

Baitimore, Maryland 21215-0020

5. Social Security Number

Delaware

Route 2

11. Medial Stetus

10e. Street and Number

Immediate Cause (Finel disease or condition resulting in death)

29b. Signeture end titla of certities

30. Nama and addrass of person who complete

Completed by Physician/Medical Examiner Be edical Certification: To

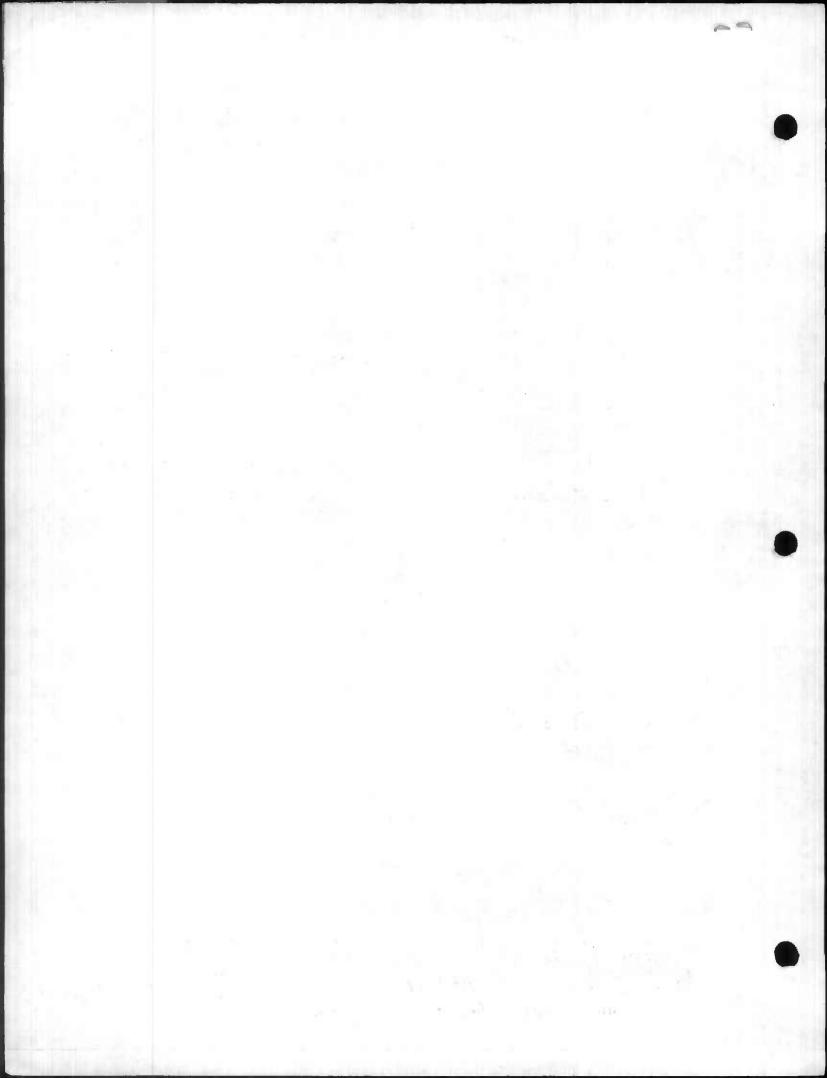
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Allows (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of):									
Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequence of):								
	1									
Pert II. Other significant conditions con	ntributing to death, but not res	ulting in the underlying o	ausa given in Pert I.	11-11-11-11-11-11-11-11-11-11-11-11-11-	tribute to the cause of death? 3 probably 4 Unknown					
Hyperte	1510			24a. Wes an autopsy performed?	4b. Were eutopsy tindings evailable prior to completion of cause of deeth? 1 Yes 2 No					
25. Wes case referred to medical examiner?			26. Place of De	eth (Check only ona)						
1 Yes 2 D	lospitel: 1 Inpatient 2	ER/Outpatient 3□ DO	OA Other: 4 Nursing	Home 5 Residence 6 □Othe	r (Specify)					
27. Manne of Death 1 Naturel 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, atc. (Specifical Control of the Control of	oma, tarm, street, tactor	28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)							

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician sorothi realing 10.16am Maria 21 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death, Examiner County Mge (In yrs. last birthday) Washington 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Hours Min. (Mapth, Days) Washington If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 6-29-1922 9. Birthplece State or Foreign **Funeral** 1□ M 21 F 78 Kansas Director 510-14-9384 with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahona 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 288-1 the Medical Examiner must be notifi-10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or Items 23s or S. A. 20213 Robinwood Court 21742 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 → Married 1 ☐ Yes ZE No Specify: White 21215-0020 Specific à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy Important: if Item 27 is marked oth eny linury or other traumatic event adds. 8 Dollie Mae Tracy Benjamin Franklin Blevins 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delbert T. Keeling / spouse 20213 Robinwood Court Hagerstown, MD 21742 Baitimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete XX Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 7-24-00 Hagerstown, MD 21. Signature of Funeral Service License 22. Name and Address of Fecility Rest Haven Funeral Chapel | 10U1 Fennsylvania Ave. nage 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Hagerstown, MD 21742 Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): anoxic Examiner oute Myscarplial Infaretion Due to (or es a consequence of): Physician/Medical Examiner cute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Heart Failune Congertive Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 908 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 70 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 ENatural 5 Pending 1∏Yes 2□No 2 Accident eg. Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, atreet, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital within 24 hours To the Funerel Completely filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) DOOZ5714 7/21/00 way MI (Item 23a) (Type, Print) 30. Name and address of person who comp 11/0 Haywood Med

State

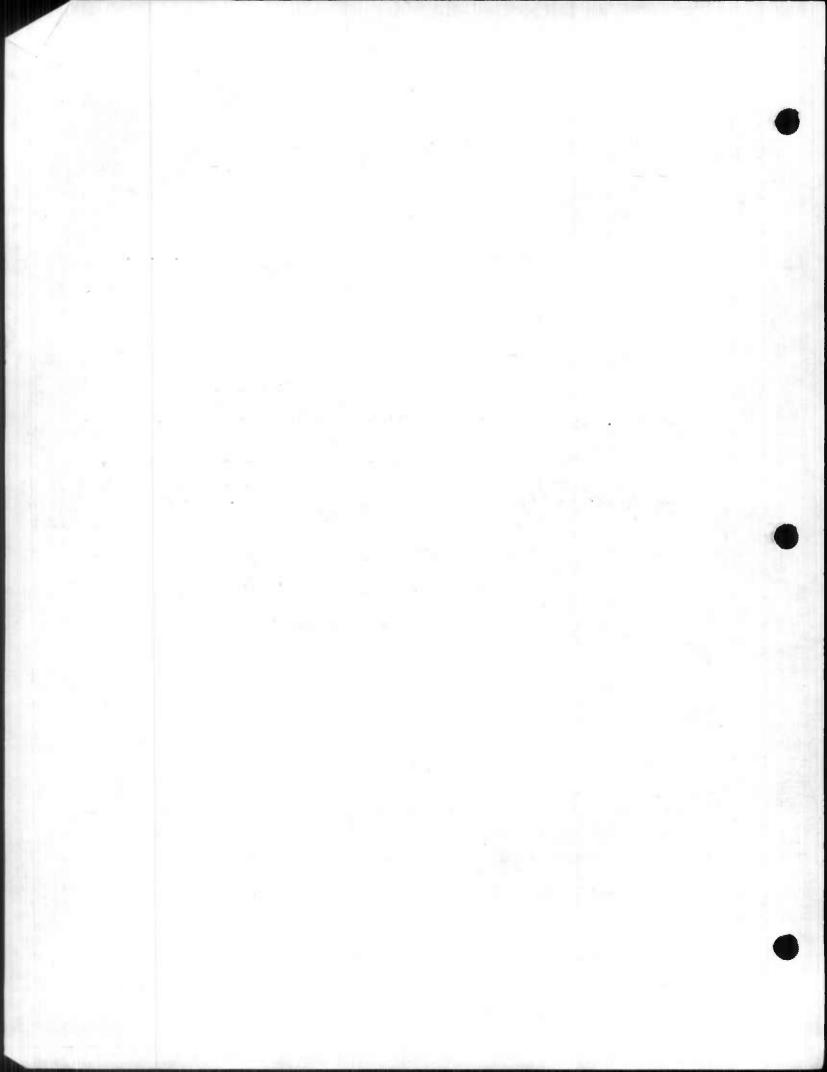
Registrar

31. Date filed (Month, Dity, Year)

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2000

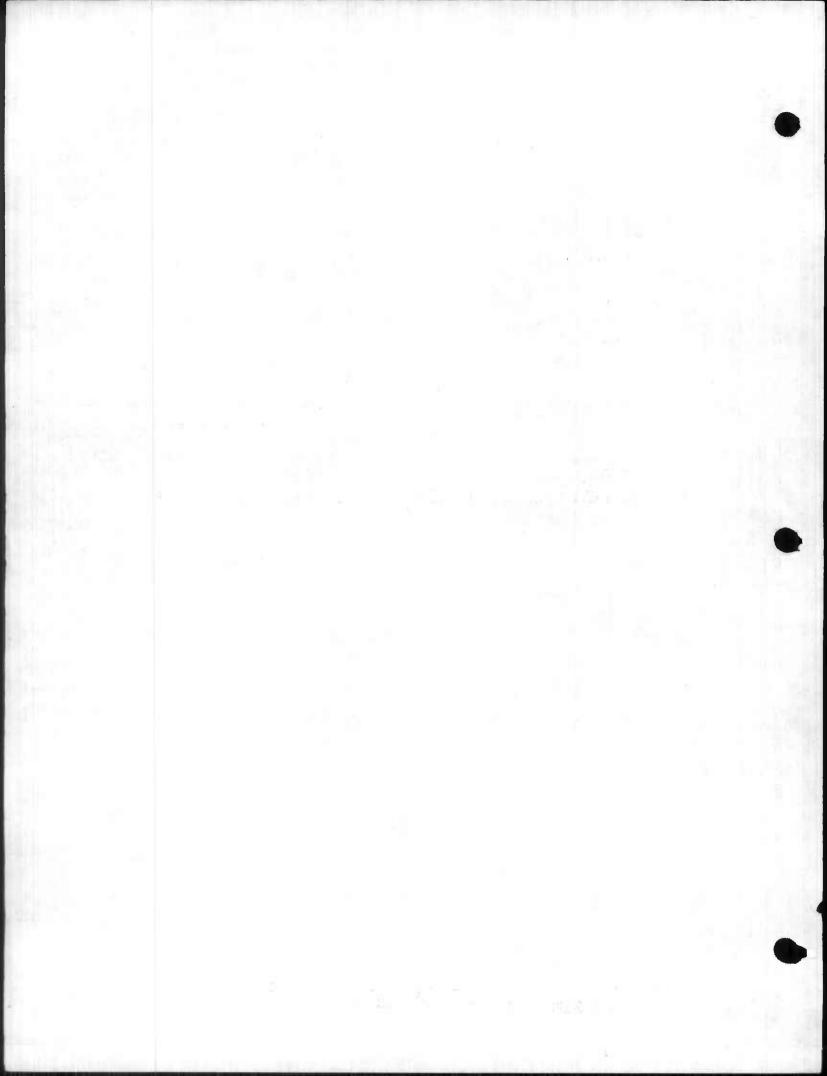
32. Registrar'a Signature



State of Maryland / Department of Health and Mental Hygiene 24826 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 24,2000 Lawrence Stewart Keener 1:00 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown r If Under 24 Hrs. 8 Hours Min. Avalon Manor Nursing Home Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Director 220-74-0315 Jan. 19, 1926 Virginia the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits mat be notified at Md. Washington TV Yes 2 □ No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s any laylary or other treumatic event, the Med 101 East First 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) N/A N/A 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Keener Louise Winslow 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10843 Peachwood Dr. Manassas, Hollis Keener/brother Va. 20110 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date **Buriel 2 Cremation 3 Removal from State 7/28 Manassas City Cemetery Manassas, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Burner Trade Services 21. Signature of Funeral Service Licensee 20: Burnel MBIE 1037 Dual Place, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 2-3-400 Preumani) disease or condition resulting in death) Examine Due to (or es e consequence of): Examiner that the death certificate be axecuted physicien and s the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) USB Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown d be deta Accident Centro Varantes Records. P 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After or Attending 1 [4Matural 5 Pending investigation n 24 hours after death.

Ne Funeral Director: After bletaly filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) - COREC MD JULY 24, 2000 P (8019 30. Name end address of person who completed cause of death (ftem 23a) (Type, Print) Dr. Vassant Datta 334 Mill St Hagerstown, MD 21740 3. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Vac **Physician** LONCZYNSKI Syan Joseph 29. JULY 2000 7:12 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner PENINSULA REGIONAL HOSPITAL SALISBURY WICOMICO If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1 № M 2 🗆 F 212028896 Yrs. Director Baltimore MD Usual Rasidence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No **Funeral Director** anover 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 234 amin 12. Was Decedent Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Marital Status Black, Whita, alc. filed within 72 hours efter 1 ☐ Yas 2 🛣 No If Yes, Giva Yaar or Datas: 1 Never Merried 2 Married 8 Saltimore, Maryland 21215-0020 1 Yas 2 No Specify λq 3 ☐ Widowed 4 ☐ Divorced "neturel", Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) uden other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Peges 1 end 2 should be fii ment of Health end Mental H lant: If frem 27 is marked out onczynski borah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta permit. Peges 1 end 2 : Department of Health er important: if item 27 ie eny Injury or other trau pacs. 20 Benjamin ONCZYNSKI Deborah 20b. Place of Disposition (Nama of camatary, crametory or other place) 20a. Mathod of Disposition 20c. Location -1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) tntarval Between Onsat and Death **Physician** tmmediate Cause (Final disease or condition rasulting in death) /Medical AND NECK INJURIE Examiner Due to (or as a consequanca of) Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) or Attending Physicien: The lew requires that the death certificate be execu of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Was 2 No 1 Yas 2 No funeral director. 25. Was casa referred to medical axaminer? Be 26. Placa of Daath (Check only ona) Other: 1 Nas 2 No edicai Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) this 28d. Describe how injury occupied RT, 50 AND
RT. 731 PASSENGEL OF AUTOIN
MOTOR VEHICLE ACCIDENT
28l. Location (Street and Number or Rural Route Number,
City or Town, Stata) RT, 50 ATORT. s efter death. 28c. tnjury et Work? 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of Division Injury 1 Natural 5 Pending 1:27 AM 1 Tas invastigation 2 Accident 3 Suicide 129/00 6 Could not be detarmined Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. Hospital within 24 hours To the Funeral 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Data signad (Month, Dey, Year) 29b. Signatura and titla of certifian 29c. Licansa number O.C.M.E. JULY 31, 2000 30. Nama and address of person who completed dausa of daath (Itam 23a) (Type, Print) MARY RIPPLE 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00 21.000

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Phys	ician	1. Decedent's Name (First, Middle, La		T 477	G037		2. Date of Dea	Day	Veer	3. Time of Death	
	dical	JAMES	NELSON	LAW	SON	4b. City, Town, or	JULY			2050	
Exan	niner	4a Facility Name (If not institution, given 26574 ROYAL OAK				EASTO			LBOT		
Funer Directo	_	5. Social Security Number 6. 9 216-34-0827 Usual Residence of Decedent	Sex 7. Age (#		If Under 1 Year Months Days			r, Year)	9. Birthplace Country) NEW YC	e (State or Foreign)RK	
9 Bu		10a. State 10b. County	10	C. City, Town or Loca	ation				10d.	Inside City Limits	
with the Maryland a or 28s-f show Lbs notified at	tor	MD ANNE AR	UNDEL	ARNO	LD					1 ☐ Yes 2 ☐ No	
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?		
9 wil		784 N. HARMONY A	VENUE		21	.012		USA			
ter des Berns Det. III	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1XXYes 2 \sum No if Yes, Give Year or Dates: 1 9	4.0	as Decedent of es, specify Cul	Hispanic Origin? (5 ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		4. Race - American Indian, Black, White, etc. Specify: WHITE		
72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Decede	nt's Usual Occu	ipation	16b. Kind of Business/Industry				
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THOSE CONTRACTOR		20a. Method of Disposition		20b. Place of Disposit			Date	20c. Location -		State	
Page ment		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JHemovai from State	PRING HILI			7-18-00	EASTON,	MD		
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		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury Month, Dey Y	28b. Time of Injury	28c. Inju	ury at ork?		now injury occurr			
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		30. Name end address of person who	completed cause of deet	h (Item 23a) (Type Pi	rint)			1	1100		
		DAVID A. STOUT,		WASHINGT(EET, EAST	ON, MD 2	1601			
	itate	31. Date filed (Month, Dey, Year)	32. Registrar's	Signature							
Regi	strar	ANT I AS	000 Dene	M.	Ann.	11					

DHMH 16 Ray 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 5, per F.D. 7/26/00, Carroll County, wjl Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death Dey Month
JULY 19, 2000

4 Pleath | 4c. County of Death Month Physician VERA JEANETTE LEISTER 12:04 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 721 WILLIAM AVE. WESTMINSTER CARROLL | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Dirth (Month, Day, Year) | MAY 11, 1926 | MARYLAND If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. 30115 Se2014.193018 **Funeral** 1□M 2♥F Days 74 219-20-9308 Director **Usual Residence of Decedent** 10a State 10b. County 10c City Town or Location t0d. Inside City Limits 1 Yes 27 No Director 28a-f CARROLL WESTMINSTER MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? must be n 21157 USA 721 WILLIAM AVE. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11 Marital Status Black, White, etc. 72 hours after d other than "nature!", or the event, the Medical Examin 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE HEALTH 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy anti: If them 27 is marked oth jury or other traumatic event Be RUTH MONROE B. WILSON ECKARD 19a. Informant'e Name/Relationship (Type, Print)HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MICHAEL D. LEISTER, JR. 721 WILLIAM AVE., WESTMINSTER, MD. 21157 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Department of Important: If any Injury or 7/21/2000 BALTIMORE, MD. 4 Donation 5 Other (Specify) METRO CREMATORY 21. Signature of Furieral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Ouzrich Carcinona Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the buriel-transit Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown Vohe Khown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1□Yes 2□No t ☐ Yes 2 ☐ No of Vital or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No the state funeral 27. Manger of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation a 24 hours efter deeth.

• Funerel Director: Aft letely filled in by the fur 1 Yes 2 No 2 ☐ Accident

State Registrar

2

Hospital

To the Hosp within 24 hos To the Fune completely fi

6 ☐ Could not be

Ja:out 2

Danst 30. Name and address of person who completed cares of death (flem 23a) (Type, Print)

m.D

JUL 2 1 2000

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Washington

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Heights

15552 (md.)

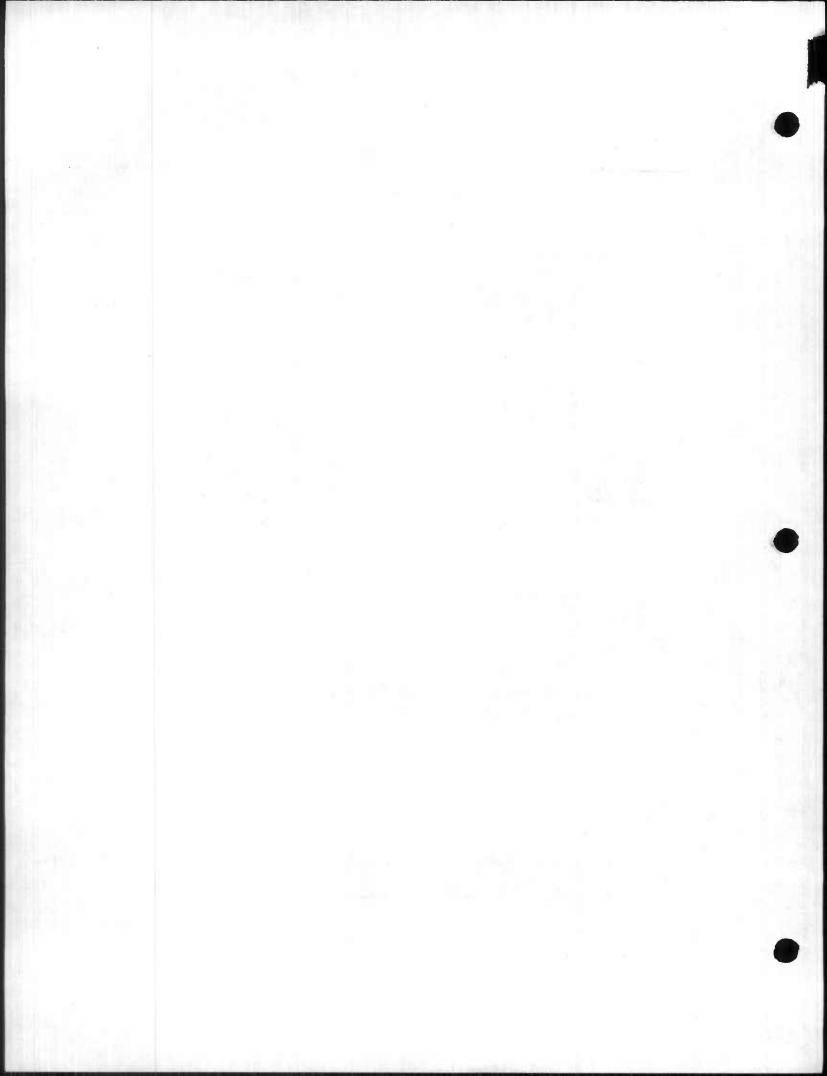
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

, M.D.

224 32. Registrat's Signature 281. Location (Street end Number or Rurel Route Number, City or Town, State)

Westminster, Md. 21157

29d. Date signed (Month, Day, Year)



Amended # 7, Whole 1/25/00, Allogary Co.

Please Type or Print in Biack Indelibie Ink. Assure Aii Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

24830

				Ce	rtitica	ite oi	Death			Reg. No.					
Physician	Decedent's Name (First, Mid Donald Earl Lloy						2. Dete of De Month	Day 21, 2	Year	3. Time of Deeth					
/Medical	4a Facility Name (If not instituti		ımber)				4b. City, To	wn, or Lo	cation of Deat		unty of Death				
Examiner															
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Funeral	5. Social Security Number	6. Sex 100 M 2□ F		s. lest birthday) Yrs.	Month			Min.	6. Dete of Bir (Month, Dr	ly, Yeer)	9. Birth	place (State or Fore intry)			
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	Usual Residence of Decedent		100.0	Dis. T								40.44 14 00 11			
natural; or items 23s or 23s-1 show alter Examiner must be notified at sted by Funeral Director	10a. Stele 10b. Coun	ry	10c. C	City, Town or L	ocation							10d. Inside City Lim			
1 0	Maryland All	egany	Fro	stburg						1 Yes 2 🗆					
or 28a-f s be notified Director	10e. Street and Number				10f. 2	Zip Code				10g. Citizer	of Whet Cou	intry?			
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"natural". o	3 Widowed 4 Divorce	Year or [Dates: WW	ا سللم							White				
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2 2 0	17. Father's Name (First, Middle	e, Last)				7.01	18. Mothe	er's Name	(First, Middle	, Maiden Su	тате)				
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T E	19e. Informant's Name/Reletion	nship (Type, Phnt)		19b. Mait	ss (Stree	ana Numbe		al Route Numb	er, City or 10	SWII, SIEIB, ZI	(p C008)				
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20	20a. Method of Disposition	. Place of Disponentery, cre	osition (A matory o	lame of r other pl	ace)	1	Date	20c. Locat	tion - City or T	own, Stete					
		State					2	5lul-00	Flintsto	ne. Man	vland				
Important: I any Injury o	4 Donation 5 Other (Specify) Maryland Veteran's Cemetery at 25-Jul-00 Flintstone, Mary														
mp onc	21. Signature of Funeral Service Licensus 22. Nama and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532														
12 4 4	John,	K.A.	week		urst F	unerc	al Home	, 57 Fi	ost Ave.	, Frostbu	irg, MD	21532			
	23a Page. Enter the disease, or heart failure. Li	or complications that	ceused the de	ath. Do not en	ter the m	ode of dy	ring, such as	cardiac c	or respiratory a	rrest,	1	Approximate Interval Between			
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aminer	disease or condition resulting in deeth)	a//	/www	me	W	166	nuc	u	RIKOL	2 hay	2	2 all			
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S P										an autopsy	24b. V	Vere autopsy findin vailable prior to			
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al Director: After 1 ed in by the funeri Certification:	1 Neturel 5 Pend 2 Accident inves	ling (Mor	in, Day (odi)	Injury	М		Yes 2	No							
Tice	3 Suicide 6 Coul	d not be	e of Injury - At	home, ferm, si	treet, fact	ory, office	9				Vumber or Ru	ral Route Number,			
Direction of	4 Homicide deter	mined 286. Plao	ling, etc. (Spec	city)	, , , , , , ,	.,,	15.24			wn, State)					
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e m	30. Name and address of person who completed case of death (Item 23a) (Type, Print)									, 2000					
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Registrar	JUL 24	2000	beneva	9	1	Down	h								

Donald Earl Loyd

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89 Hill Street

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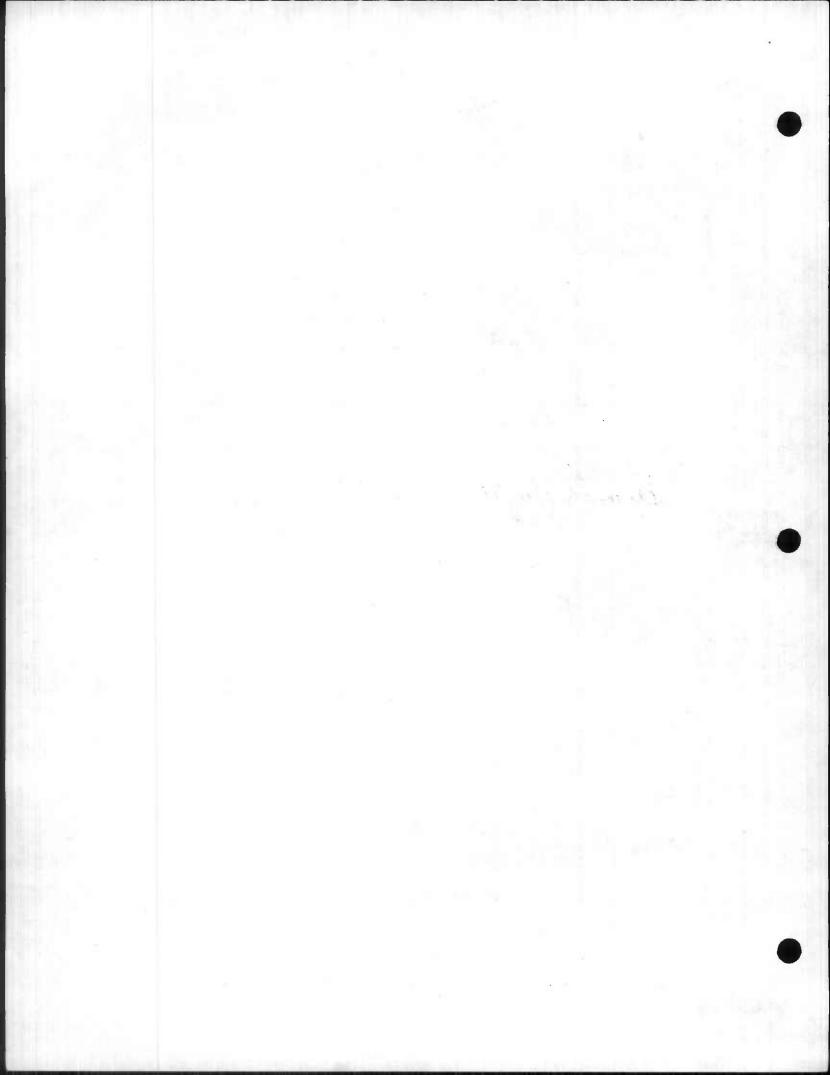
Durst Feneral Home, 37 Fast Ave., Hustberg, MD 21532

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

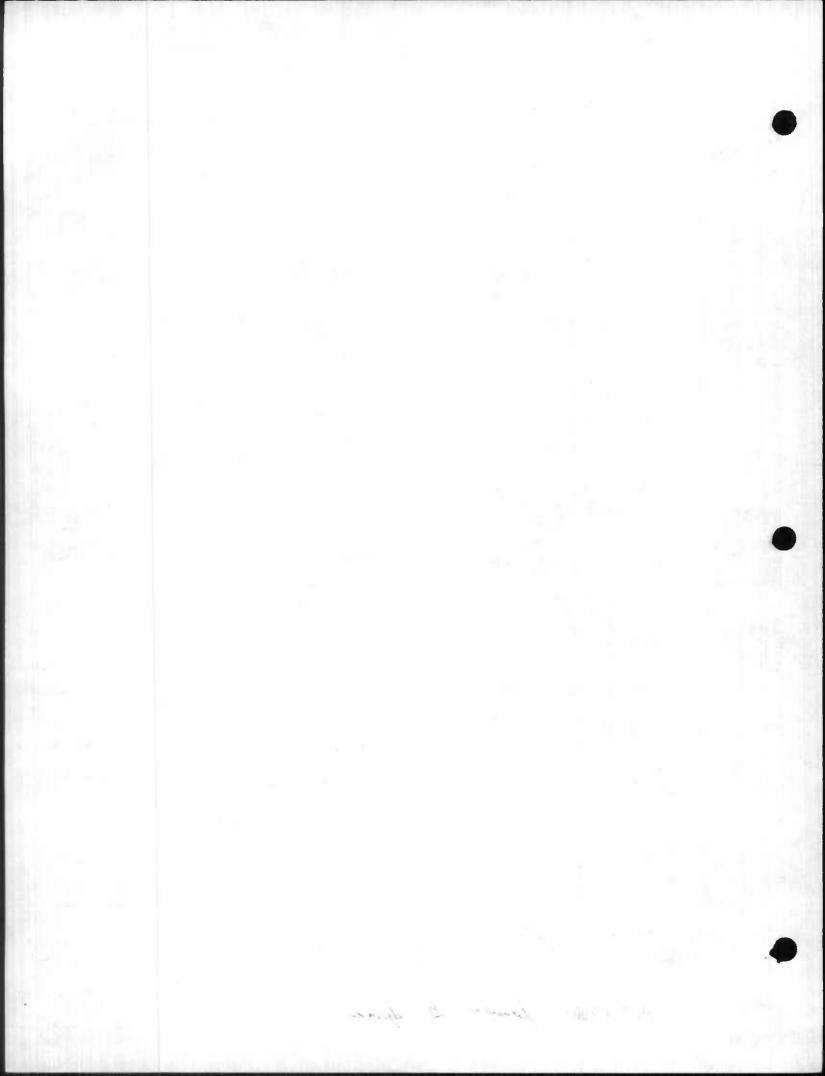
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Funeral Director	5. Social Security Number 220-24-4760	10	x 7. Ag XM 2□ F 7	ge (In yrs. last t	oirthday) Yrs.	If Under 1 Yea Months Dey:		Min. 8. Dete of B (Month, D		9. Birthple Counti Md	eca (Steta or Foreign ry)
10	Usual Residence of Deci	edent									
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n with the Ma da or 28e-f a at be notified al Director	10e. Street and Number 3330 Pfeffe	erkorn :	Road			10f. Zip Code 21794	+		10g. Citizen of USA	Whet Count	ry?
020 urs after dead str. or flams 2 Examiner mu	11, Marital Stetus 1 Never Merried 3 Widowed 4		12. Was Decedent Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:			as Decedent of /as, specify Cu Yes 2 No		gin? (Specify Yes or N , Puarto Rican, atc.)		ce - Amarica ck, Whita, a y: Whit	fc.
O of File D	15. [Decedent's Edu	ecation	16	a Decede	nt's Usuaf Occi	ination		16b. Kind of B	usinass/Indu	ustry
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Balti Depart Importa anti-	21. Signature of Funerel	1	Haight					HOME & CHA			
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/Medical	Immediate Cause (Final									į	
Examiner	disease or condition resulting in death)		. <u>m</u>	Due to (or as			W 4	ANCER		1	2 mants
oxecuted in and instransit	Sequentially list condition if any, leading to immedia	ns, ata	b	Due to (or es	e conseque	ence of):					
6876(difficete be g physicie es the bu	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	1	c	Due to (or as e	conseque	nce of):				1	
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by bed the					-				Yes 2E-No	T	ably 4 Unknown
4 2 W CL DL								24e. We per	s en eutopsy ormed?	ave	ra eutopsy findings ilable prior to aplation of causa eath?
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- 2 00	1 Yes 2 No		1 L Inpatie	ent 2 ER/C		3LI DON	4 LI Mui	rsing Home 5 D Res)
Vision of Attending P art of State of by the funerial file of the funerial file of the state of	2 Accident	Pending investigation	28a. Data of Inju (Month, Da	iy Year) 28b.	Time of Injury	28c. fnj W M 1[uryat ork? ⊒Yas 2∐N		how injury occur	red	
Division of the or Attending P as after death. In Director: After the funer led in by the funer. Certification:	3 Suicide 6 L 4 Homicide	Could not be detarmined	28e. Place of fn building, et	jury - At homa, c. (Specify)	farm, stree	t, factory, office	•	28f. Location City or To	(Street and Numi own, Stete)	ber or Rural	Route Number,
Hospi 24 hou 24 hou Funer taly fill				f examination a				place, end due to the h occurred et the time			
To the comple	29b. Signature and title of	f certifier				29c. Licer	nse number		29d. Date signe	ed (Month, D	Pay, Year)
F 3 F 8	1 &	11	de	_ 2017	77		0259	47	JULY 18		
	30. Name and address of	perad who or	impleted ceuse of d	leath (Item 23a) (Type, Pr	int)					
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Registrar	111	1 2 0 2	nnn 🕨	new	19	Som	1.1				



State of Maryland / Department of Health and Mental Hygiene 00 24832

		Certificate of Death	Reg. No.	47006
	1. Decedent's Name (First, Middle, Last)	100 100	2. Date of Death Month Day	3. Time of Death
Physicia: /Medica	MADIENTE MADCADET MODDIO		JULY 20 200	
Examine	An English Name (Mant Institution aire street and over task	4b. City, Town, or L		
	237 HENDERSON AVENUE	CUMBERLA	ND ALL	EGANY
Funeral Director	5. Social Security Number 215-34-4384 Usual Residence of Decedent	rithday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	9. Birthplace (State or Foreign Country) MARYLAND
D B 11		m or Location		10d. Inside City Limits
Mary Fath	MARYLAND ALLEGANY CUN	MBERLAND		ty∏Yes 2 No
ath with the Mary 123e or 28e-f sh wat be notified.	MARYLAND ALLEGANY CUN 10e. Street and Number	10f. Zip Code	10g. Citizen of Wi	hat Country?
th will		21502	U.S	. A .
aher da	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedant Evar in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give ⁴ Year or Datas:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerlo		- American Indian, , White, etc. WHITE
5-0 72 ho	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 9 16a	Decedent's Usual Occupation	16b. Kind of Bus	iness/Industry
21 Men	Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	any	
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DE SER	17. Father's Nama (First, Middle, Last)		e (First, Middle, Maiden Sumame)
The state of	MERLE DICKEN		. WINTERS	
Ma d 2 st d 2 st T to an		 Mailing Address (Street and Number or Rules 37 HENDERSON AVE CUM 		
- 5500	20a. Method of Disposition 20b. Place 0	of Disposition (Name of		City or Town, State
Baltimore semit. Pages 1. Separation of Hu mportant: if ten my injury or oth ms.	1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State	AWN CEMETERY JULY 24	William To Committee	
Ball permit permit angle angle	21. Signature of Funeral Servica Liberary	22. Name and Address of Fecility MERRITT-ADAMS FUNE 404 DECATUR STREET		YLAND
Certificate be executed dring physician and use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated evants resulting in death) Last	consequence of): Carci consequence of): Consequence of):	rema of Laki to the	Onset and Death 6 Mc
death cer death cer e attendin				
P.O. hat the d by the detach	Part II. Other eignificant conditions contributing to death but not resulting. Rheumatod Arthut 3,	Ovanian		tribute to the cause of death? 3 Probably 4 Unknown
need need	Cancarna Prenigheral	VAscoler	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	Biserie Commence (d.	de Arons	1 ☐ Yes 2 🖾 No	1 ☐ Yes 2 ☐ No
Vital I		26. Place of Dee	th (Check only one)	
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursing H	ome 5 ⊋Residence 6 □Other	r (Specify)
Jing Phys. After this funeral d	27. Manner of Death 28a. Date of Injury 28b. 1 ☑ Netural 5 ☐ Pending (Month, Day Year)	Time of 28c. Injury at Injury Work?	28d. Describe how injury occurre	d
or Attendent director: In by the	2 Accident investigation 3 Suicida 6 Could not be determined 4 Homicide determined building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
Hospi 24 hour Funer		s, deeth occurred at the time, date and place, ad/or investigation, in my opinion, death occur	end due to the cause(s) end men red et the time, date and place, er	ner as stated. nd due to the ceuse(s)
To the method to the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
5	New Malking	D 0054411	JULY 21,	2000
	30. Name and address of person who completed cause of death (Item 23a)	1/		
nd		OSPITAL MEDICAL BUILD	ING CUMBERLAND	MARYLAND
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ina. V.		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 20, Clarence Urban McKenzie 2000 Jul 06:55pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 804 White Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10M 20F Yrs. Director 83 220-03-7619 Mar 26, 1917 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director 28s-f Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Berns 23a 804 White Avenue 21502 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yas, Giva
Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1□ Yes 2□ No Specify Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygiens important: if fleen 27 is marked other tha any Injury or other traumatic entire tha 9058. 12 Director of Finance Queen City Dairy 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 98 Clarence V. McKenzie (Dunn) Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Elizabeth McKenzie 804 White Avenue; Cumberland, MD21502 Was Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Par7/23/ Cumberland, MD
22. Name and Address of Facility
Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting In death) /Medical · WIDESPREAD METASTATIC DISEASE Examiner Examiner ettending physician end for use as the burial-transit tha death certificate be axecuted Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 TNo 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director. It 25. Was case raferred to medical examinar? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannet of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number and Date signed (Month, Day, Year) and address of person who complated cause of death (Item 23a) (Type, Print) Williams M.D. Memorial Hospital Med Blg Cumberland MD 21502 YIW Terry E

Registrar

31. Dete filed (Month, Dey, Year) JUL 2 5 2000 32 Registrar's Signature

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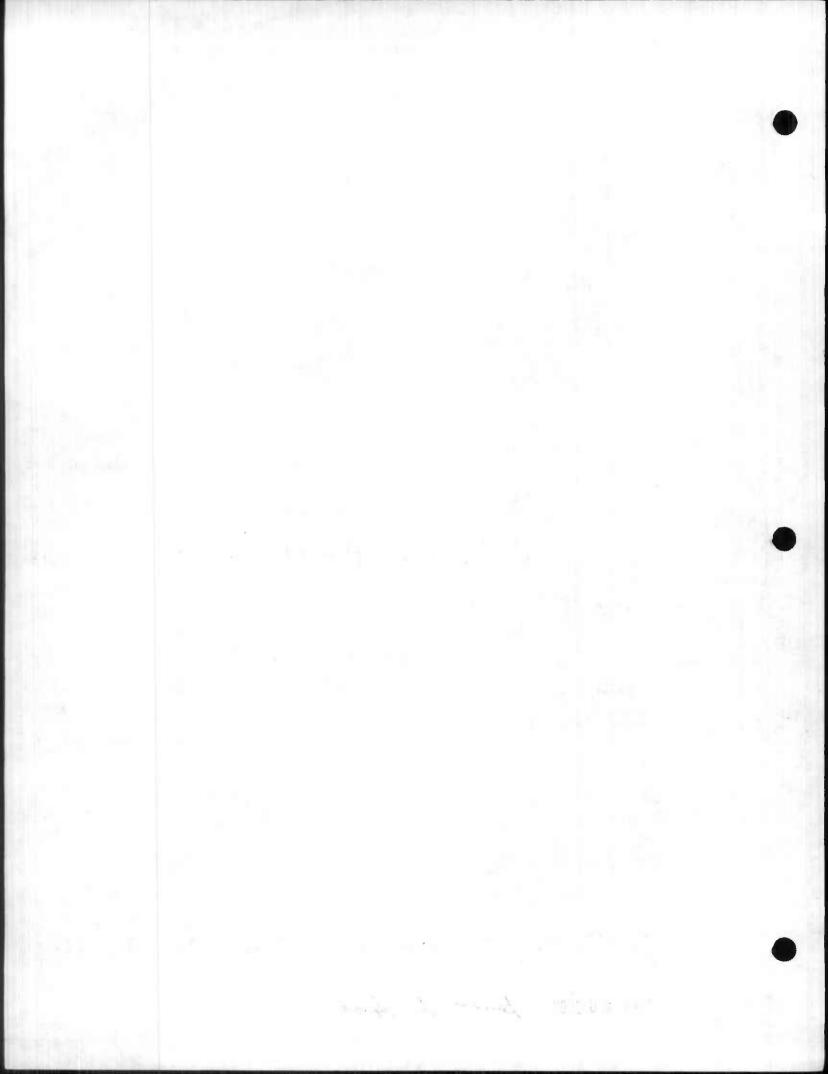
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	Examiner	4e Fecility Name (If not institution, Sacred Heart						wn, or Local rlanc	tion of Death	4c. County		egany
	Funeral Director	5. Social Security Number 170 – 50 – 2815	6. Sex 1 M 2 F	7. Age (In yrs. last bird 96	Yrs. If Ur Mont	hs Deys	If Under 2 Hours	Min. NC	Dete of Birth (Month, Day DV 11	Year) 1903	9. Birthp Coun	place (State or Foreign MD
	D	Usual Residence of Decedent										
	Marylan a-f show iffed at	PA Som	erset	10c. City, Town	or Location Velle	rsbur	g				1	0d. Inside City Limits
	ter death with the Marylar terms 23a or 28a-1 show the must be notified at the mast be notified at "uneral Director".	10e. Street and Number P.O. Box 15			101.	Zip Code	155	64	1	10g. Citizen of Whet Country? USA		
020	a 9 2	11. Meritei Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	ve	if Yes,	ecedent of H specify Cuba s 2 No	ispenic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race Bieck		
21215-0020	within then the months of the	15. Decedent's (Specify only highest Elementery/Secondery (0-12)	s Education grede completed) College (1-40(54)	Decedent's L (Give kind of life. DO NO nemake	work done of use retired	etion during most	of working		16b. Kind of Bu		dustry
Maryland 2	should be filed and Mental Hygia marked other umatic avent, II	17. Fether's Neme (First, Middle, L Michael H. Ga:					Marga	aret	R (5	Meiden Surmern Seise)		
	nd 2 sh olth end 27 is m r treum	19e. Informent's Neme/Reletionshing Gary Starkey grandson	ip (Type, Print)	621	Meiling Add	le Ci	bnd Numbe ty Ro	or or Rurel R	Route Numbe Meyers	r, City or Town, sdale I	State, Zip PA 1	Code) 5552
Baltimore,	2007	20a. Method of Disposition ↑□ Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (Spe		State Cook S	y, cremetory	or other plea	е)		Dete / 26 /	20c. Location		rg, PA
Balti	pemit. Peg Department Important: Il any Injury o pace.	21. Signature of Funeral Service L	censee	1 00000-	S'c'ar			meral	Home	e, P.A.		ig, in
-		23e Pert1 Enter the disease or o	omus utions that o	raused the death. Do r						rest	1	Approximete
	Physician /Medical	23e. Pert1. Enter the diseese, or of shock, or heart failure. List of Immediate Ceuse (Final	niy one cause on e)		node of dyn	g, 50011 55	out dies of the	50p.15101.y 511			Onset end Deeth
	Examiner	disease or condition resulting in death)	0.	neumon	189							Zweeks
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90,	physician and sthe burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	C.	Due to (or e's e o	consequence	of):						
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Records,	aw requires to been so 2 should pleted								24e. Was a perfor	an eutopsy med?	ev:	ere eutopsy findings ailable prior to impletion of cause deeth?
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ita	certificete rector, pag	25. Wes case referred to medical					26. Piece	of Deeth (Check only o	ne)		
2	2 00	examiner? 1 Yes 2 No	Hospitel:	Inpatient 2 FENOu	tpatient 3	DOA Oth	er: 4 🗆 Nu	rsing Homa	5 Resid	lence 6 Othe	er (Specif	(y)
Division of Vital	Attending Phinded of the Attention of the funantial of th	27. Menner of Death 1 Naturel 5 Pending 2 Accident investiga	ation		Time of njury	28c. injur Wor 1	yat k? Yes 2⊡		d. Describe h	ow injury occurr	ed	
Divis	is or Attending P rs effer deeth. al Director: After t ed in by the funant Certification:	3 Suicide 6 Could no 4 Homicide determin	of be ned 28e. Plece buildi	e of tnjury - At home, fe ing, etc. (Specify)	rm, street, fe	ctory, office		281	f. Location (S City or Tow	itreet end Numb n, State)	er or Rura	al Route Number,
	ne Hospi n 24 hound ne Funer plataly fill edical	29e, Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the b	best of my knowledge asis of examinetion en- per stated.	, deeth occur d/or investige	red et the tin tion, in my o	ne, date en pinion, dee	d plece, end th occurred	d due to the d et the time, d	ause(s) and me date and piece, o	nner es s and due to	stated. the ceuse(s)
	Within To the company	29b. Signeture and title of certifier	11/	//		29c. Licens	e number			29d. Dete signed	~ 11	
	6	* Manne	6/1	Roya delle	MA	0	35	135		JULY	24	,2000
	This	30. Name and eddress of person w	no completed saus	se of glooth (item 23a) ((Type, Print)	9	ZS	e Lan	D-C	Cymb	ede	und MI
	State Registrar	31. Dete filed (Month, Day, Year)		neglsyer's Signeture	doo	els				100		

State of Maryland / Department of Health and Mental Hygiene 24835 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jul 23, 2000 Miller Helen Regina /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner New Hope Personal Care Home Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Dec 30, 1904 Director 219-44-1178 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or forms 23s or 28s-f show traumede avent, the Medical Examinar must be nothed at 10d. Inside City Limits 1. Yes 2 No Director Allegany Cumberland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 1427 Magnolia Court 21502 death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indien, permit. Peges 1 and 2 should be filed within 72 hours after c Inopartment of Health and Mental hyglene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Examination. Bleck, White, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1□ Yes 2□No Specify Specify white by 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) Daniel Arnold Ruth (Miller) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Norma Jean Miller 6945 Fairway Dr East Fayetteville, PA17222 daughter in-law 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 7/26/ Cumberland, MD 21. Signature of Funeral Service Licenses Scarpelli Fulleral Home P.A. Cumberland, Maryland 23a. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart lailure. List only one cause on each line. Approximata Intervel Between Onset end Death Physician disease Immediate Cause (Finel /Medical diseasa or condition resulting in death) Examiner Examine physician and the burial-transit certificate be executed Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): signed by the aid P.O. 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 4 Unknown 1 Tyes 2 No Records, à 24b. Wara autopsy findings avellable prior to 24a. Was an eutopsy parformed? Completed completion of cause of death? page 2 s 1 Yes 20 No 1 Yea 2 No of Vital 25. Wea case referred to medical examiner? Be 26. Placa of Death (Check only one) Personal 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Care Home funarai 28d. Describe how injury occurred 27. Manner of Death 1 ZhNatural 28b. Time of To the Hospital or Attanding Pt within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? edicai Certification: 5 Pending investigation Division 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28l. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, end dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License numbe 29d. Dete signed (Month, Dev. Year) 29b. Signeture and MO 2000 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) TRAS Rapp. 912 Seton Drive; Cumberland, MD 21502 Robert E. M.D.: 32 Registrar's Signature

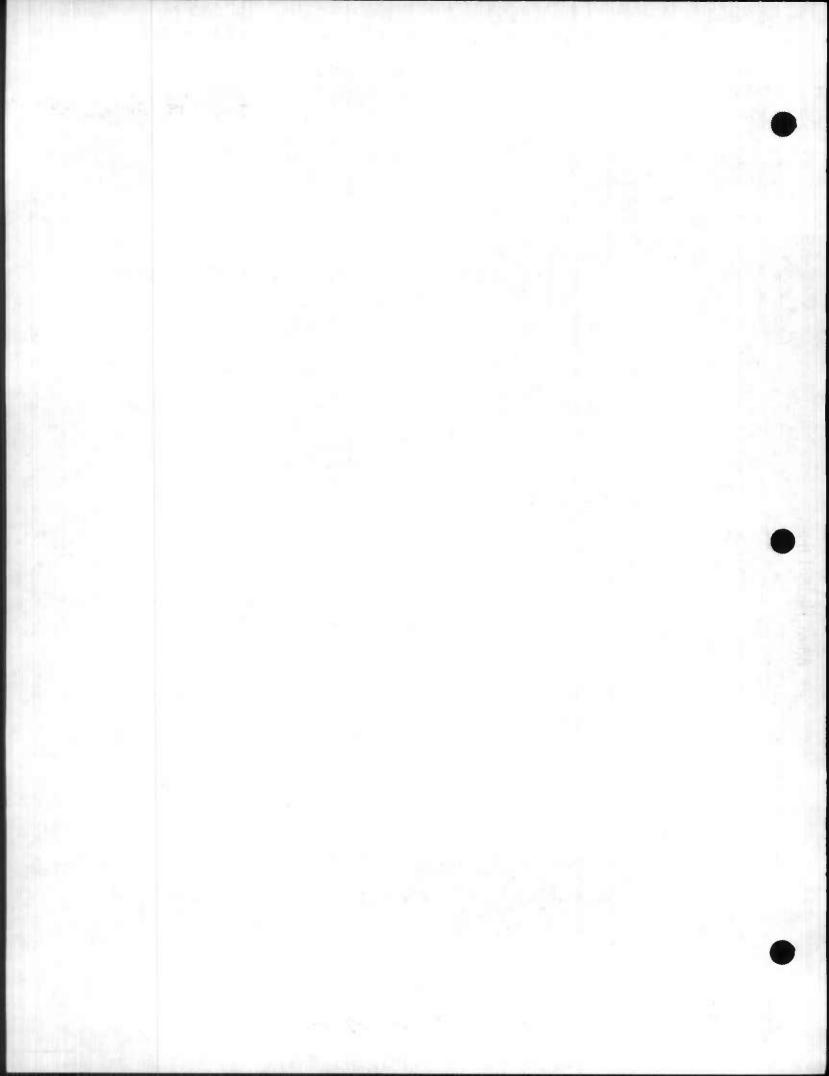
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State Registrar



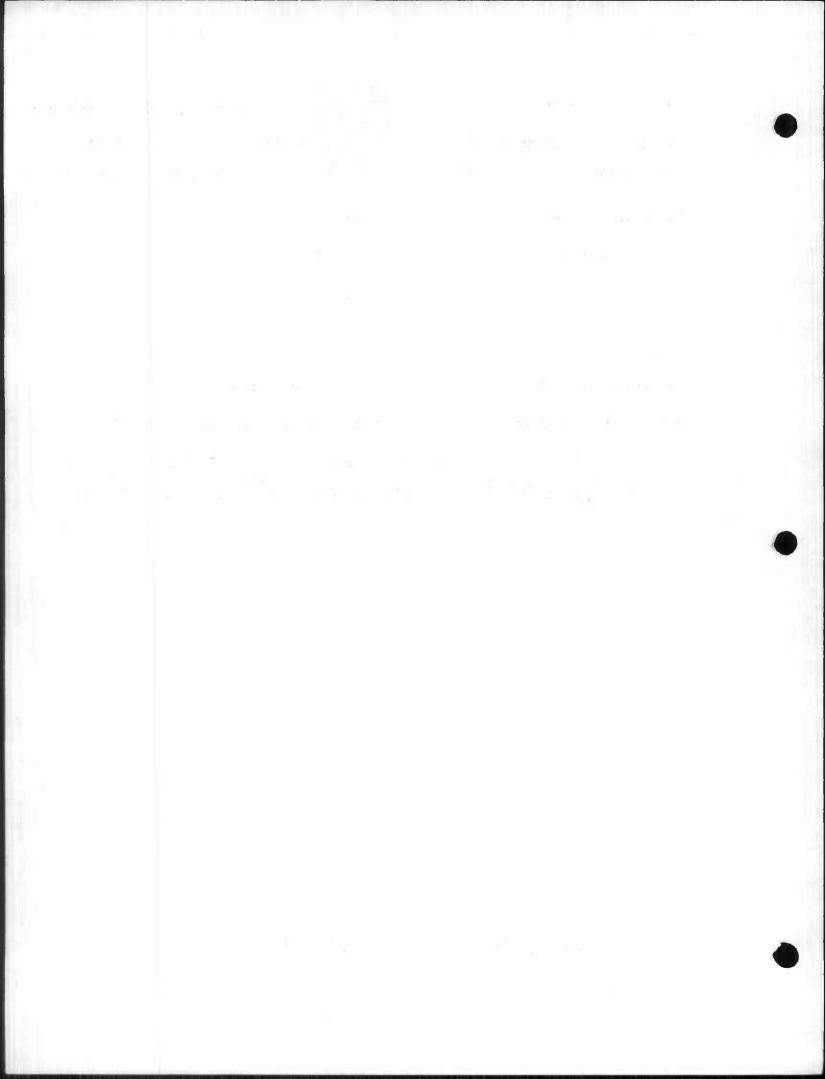
State of Maryland / Department of Health and Mental Hygiene 00 21, 226

									Death			Reg. No.			
	1. Decedent's Na	ame (First, Middle	e, Last)		1200	1 1 3 3					2. Date of De		Yea		3. Time of Death
sician edical	H	OWARD	HE	NRY	MONI	V					July	15	200		1650
iner	4a Facility Name	(If not institution	n, give str	eet end num	ber)				4b. City, T	own, or L	ocation of Deet	h 4c. Co	unty of De	eth	
	WASHIN	GTON COL	UNTY	HOSPI'	TAL					ERST			HING	TON	
	5. Social Security		6. Sex	7 1 2□ F	. Age (In yrs.		y) If Unc	ler 1 Yea s Deys		r 24 Hrs. Min.	8. Dete of Bir (Month, De	th y, Year)	9. B	Birthple Country	ce (Stete or Forei
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Director	10e. Street and N	Washi	Higuc)[[Hagers		Zip Code				10g. Citizen	of What (Country	17
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	11. Marital Status				tent Ever in U	J.S. 13	. Was Dec	cedent of	Hispanic O	rigin? (Sc	ecify Yes or No	s or No- 14. Race - Americ			Indian,
		arried 2 Marri		Armed Ford	ces?		If Yes, s	pecify Cu	ban, Mexica	an, Puerto	Rican, etc.)		Black, Wi	hite, etc	0.
		d 4 □ Divorced		If Yes, Give Year or Dat	les: 1943	3-45	1 🗆 Yes	NO.	Specify	<i>/</i> :		Spe	ecity: W	hite	е
		15. Decedent				16a. Dec	16a. Decedent's Usual Occupation (Give kind of work done during most of work					16b. Kind o	of Busines	ss/Indus	stry
		pecify only highes econdary (0-12)	st grade c	College (1-4or 5+)			(Give kind of work done during most of wor life. DO NOT use retired)				ing				
	7	7		o diago (machinis					machi	ne c	ompa	any
	17. Father's Nam	ne (First, Middle, I	Last)					18. Mother's h			e (First, Middle	, Maiden Sur	name)		
	David	Henry	Mo	Monn						la	Olive	Doyl	e		
	19e. Informent's	Neme/Relations	hip (Type	, Print)	0. 5.	19b. Mai	iling Addre	ss (Stree	et end Numb	ber or Ru	rel Route Numb	er, City or To	wn, State	e, Zip C	ode)
	Thelma	G. Monn	/ wi	lfe		1222	29 We	West Lawn Lane, Hagerstown, MD 21740						40	
	1 St Burial 2 Cremation 3 St Hemovel from State							osition (Name of Date 20c. Location - City or Town, Smelory or other piece)						n, State	
	4 Donetion 5 Other (Specify) Mt. Zion Cemetery 7/21/00 Quincy,										cy,	PA			
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility														
	Grove-Bowersox Funeral Home, Inc. 50 S. Broad St., Waynesboro, PA 1726												268		
al	Immediete Caus			HY	PER	KAL	Em	1A						1	onset and Death
/Medical Examiner	Immediate Caus disease or condinesulting in deelf Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	conditions, immediate inderlying or injury ints	a b c	P	ENA Due to (i	or es a conse	equence of	01): UPA 01): EAP		PAILI	PRE				Onset and Death
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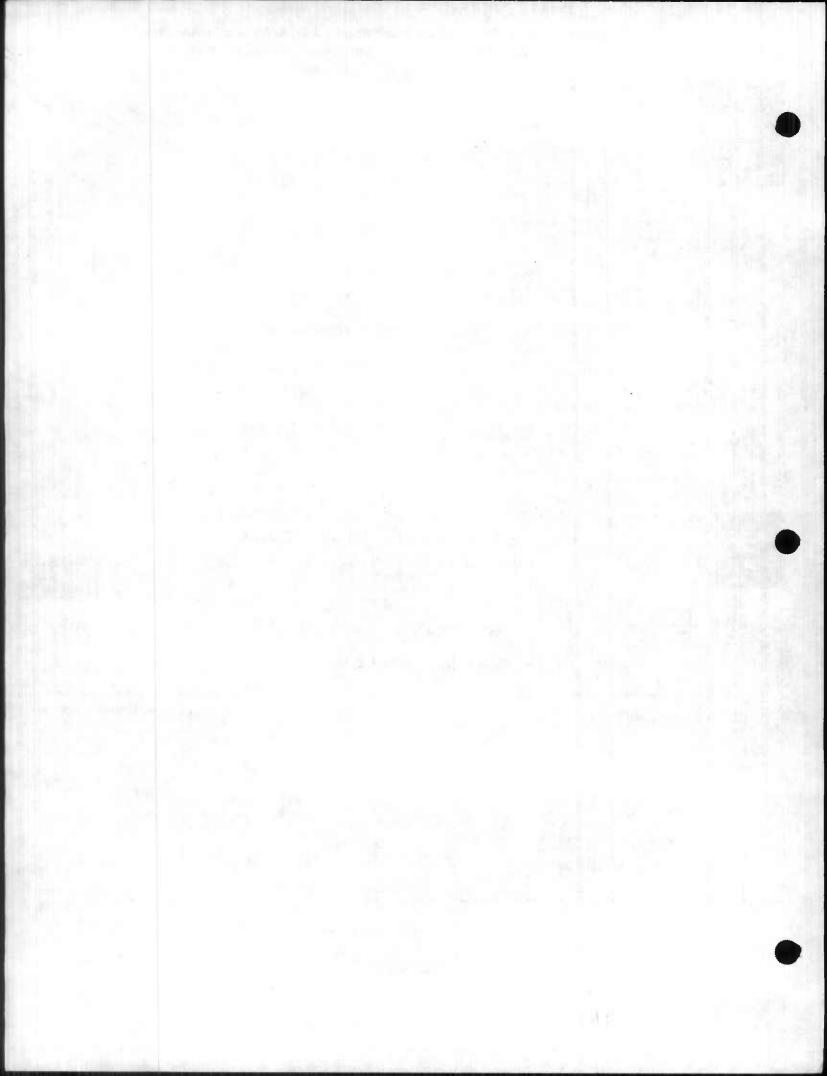
State of Maryland / Department of Health and Mental Hygiene

					C	Pertifica	te of	Death			Reg. No.				
Division		1. Decedent's Name (First, Middle,							2	. Dete of De Month		Voes	3. Time of Deat		
Physic /Med		Betty Jane Moo	re								17, 2	2000 Year	7:30 p.		
Exami		4e. Fecility Neme (If not Institution,	give street and numbe	r)				4b. City, Tow	n, or Loca	tion of Deet	h 4c. C	county of Death			
		Williamsport R	etirement	Villa	ige			Will:				Wash:	ington		
Funeral Director		5. Social Security Number 214–28–0060 Usual Residence of Decedent	. Sex 7. / 1 ☐ M 2 ☑ F	Age (In yrs.	last birtho	Months	Deys		Min.	Dete of Bir (Month, De Sept. 3	th ey, <i>Year)</i> 3,193(Cou	place (Stete or For intry) ryland		
ž		10a. State 10b. County		10c. Ci	ty, Town o	r Location							10d. Inside City Lin		
4 show	0	Maryland Wash	ington		Has	gersto	√n						1¾ Yes 2 □		
28e	rec	10e. Street and Number					p Code				10a, Citize	en of Whet Cou	intry?		
s 23a or must be	Funeral Director	12 South Walnut	Street	t Francis I	1.0		21	740	-0 /0		USA				
ene. than "natural", or items 23a or 28a-f show fra Medical Examiner must be notified at	by	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces	s? No	,,5.	If Yes, spe		Hispanic Origi an, Mexican, Specify:	Puerto Ric	can, etc.)		Black, White			
netur lice	ted	15. Decedent's (Specify only highest)	Education			ecedent's Usu		pation during most of	of working		16b. Kind	ind of Buainess/Industry			
	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	- In	e. <i>DO NOT</i> (ise <i>retire</i>	during most o	or wonding		garm	ent fac	ctory		
d other	Be C	17. Fether's Neme (First, Middle, La	st)					18. Mother's	s Name (F	First, Middle,			J		
# D .	ToB	Walter E. Marsh	a11					Nora	ner's Name (First, Middle, Melden Surmame) a Myrtle Churchey						
th and Mental I 7 is marked or traumatic eve	-	19a. Informent's Name/Relationship	(Type, Print)		19b. M	ailing Addres	s (Street	end Number	or Rural Route Number, City or Town, Stete, Zip C				p Code)		
# K		Debra Myers - da	aughter		213	Sunse	et A	venue,	Will	iamsp	ort,	Md. 217	795		
		20a. Method of Disposition		1	Piaca of D	sposition (Na	me of			Date		ation - City or T			
¥ # 7		1 ⊠ Buriel 2 ☐ Cremation 3 ☐ Removei from Stete										rstown	Maruland		
ortar ortar Injun															
Departme Importan any Injur		21. Signature of Funeral Service Liberiaee 22. Name end Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740													
nysician Medical		shock, or heert failure. List or											Approximate Interval Between Onset and Deeth		
kaminer	ner	disease or condition resulting in death)	e. CHRONI			MCTIVI sequence of)		Purmon	SARY	BISE	EAS€	1	YEARS		
attending physician and for use as the burlat-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		Due to (or as a consequence of): Due to (or as e consequence of):										
ding J	2		d						*						
for u	clan														
ched	ysic	Pert II. Other significant conditions	contributing to death	but not res	ulting in th	e underlying	cause gi	ven in Part I.					o the cause of dea		
igned by the a	by Physician/	CONGESTIVE A	FEART	FAIL	NRE					100	Yes 2	No 3□Pro	bebly 4 Unkn		
		BIATSETES N	NELLITUS							24a. Was perfo	an autops med?	9	ere autopsy finding valiable prior to completion of cause death?		
s been s 2 should	Completed									10	Yes 2 🖸	N o 1	☐ Yes 2☐ No		
has been s ye 2 should	1 (3)	25. Was case referred to medical						26. Plece o	of Death (0	Check only o	one)				
has been s je 2 shouid	0	exeminer?						ner: 4 Nurs	ing Home	5 Resid	denca 6	Other (Speci	(fy)		
is certificate has been s director, page 2 should	Be	exeminer? 1 ☐ Yes 2 🛣 No	1 Inpa							Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred					
is certificate has been s director, page 2 should	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury ey Year)				rk? Yes 2∐No							
is certificate has been s director, page 2 should	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	ey Year)	Inju ome, farm	М	1 🗆		0			Number or Rui	al Route Number,		
 4 nous are dean. Funerel Director: After this certificate has been s tely filled in by the funeral director, page 2 should 	Certification: To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying I	28a. Date of In (Month, D	njury - At hetc. (Specific of my knoof examina	ome, farm.	M street, factor	1 □ y, office at the ti	Yes 2 □ No	o 28f	Location (: City or Tou	wn, State) cause(s) a	nd manner as	stated.		
4 hours after death. Funerel Director: After this certificate has been s tely filled in by the funeral director, page 2 should	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier (Check only 12 Medicat Ex	28a. Date of In (Month, E) 28e. Piaca of It building, 6 28e. Physician: To the besignment: On the basis	njury - At hetc. (Specific of my knoof examina	ome, farm.	M street, factor	1 □ y, office at the tii	Yes 2 □ No	o 28f	Location (City or Tou	wn, State) cause(s) a date and p	nd manner as	stated. o the cause(s)		
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State of Maryland / Department of Health and Mental Hygiene 00 24838

				Ce	rtifica	te of	Death		Reg. No.		
		1. Decedent's Nama (First, Middle, La	ist)					2. Date		Meson	3. Tima of Death
	Physician		Nicholson					June	b 5 Day	200	0 0115
	/Medical	As Essilitu Name (Mast institution of					4b. City, Tow	n, or Location of		ounty of Deat	0
	Examiner						Facto	n n		lbot	
_		The Memorial 5. Social Security Number 6.5		n yrs. last birthday	If Unde	er 1 Yaar	Easto				holeca (State or Foreign
	Funeral		I M 2 ME	Yrs.	Months		Hours	Min. (Mont	h, Dey, Year)		hplaca (State or Foreign untry)
	Director	Usual Residence of Decedent	78			1		Sept	.3,1921	Mary	Land
1	1	10a, Stata 10b, County	10	Oc. City, Town or L	ocation			1-1-1-1			10d. Insida City Limits
	4 ahow	Manual and 1	A	77 20							1 ☐ Yas 2 No
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,	with the Ma a or 28a-fa De notified	10e. Street and Number			107. 2	ip Code			Tug. Chize	n of What Co	untry /
	ma 23a	105 Scott town R	oad			1679	1 51		USA		
		11. Marital Status	12. Was Decedent Eva Armed Forces?	r in U,S. 13.	Was Deci	edent of hecify Cubi	lispanic Origi an, Mexican,	in? (Specify Yes Puerto Rican, at	or No- 14 c.)	. Race - Ama Black, White	
0			1 Yes 2 No		1□ Yes	- 4	Specify:	1100	pecify:		
21215-0020	I by		Yaar or Dates:						3	B1	ack
5-0	led within 72 ho ygjena. Ne than "naturi it, tra Modell Completed	15. Decedent's E (Specify only highest gr		16e. Dece	edent's Usi	ual Occup	ation during most	of working	16b. Kind	of Business/	Industry
21	o o	Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT	use retire	d)				
21	S S S S S S S S S S S S S S S S S S S	8		Cod	ok	100			Balt	imore	City School
	EI TE	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, M			
land	Mental Mental Mental To B	William Joh	nson				Mary	Elizab	eth Ha	rris	
Maryland		19a. Informant's Name/Relationship	Type, Print)	19b. Mail	ing Addras	ss (Street	-	or Rural Route N			Zip Code)
Σ	Ith and Ith an	Jeanette Harris	/ Daughter	105	Scot	t to	m Rd	, Wye Mi	11c Mar	wland	21670
é .	Head	20a. Method of Disposition	ation - City or								
2	nt of it	1 ☐ Burial 2 💢 Cremation 3 [Capitol				6/7/20			
altimore	ant. Pe bartmer cortant: Injury	4 Donation 5 Other (Speci	ver,De	laware							
Bal	permit. Pe Departmen Important: any Injury ance.	21. Signature of Funeral Service Lich	nsee	2			ss of Facility	uneral H	Iome		
	0.05 6 0	1		3	P.O.	Box :	1687.	Easton.M	farvland	21601	
		23a. Part1 Enter the disease, or com shock, or heart failura. List only	plications that caused the	e death. Do not er	ter the mo	de of dyir	ng, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between
F	hysician	7 0.1001, 0.11011.11011.1101	Altresso	sclend	100 . 4	leau	It de	reare			Onsat and Death
	/Medical	Immediate Cause (Final disease or condition		GI lileed							Caland
E	Examiner	resulting in death)		e to (or es e conse		١.					> anys
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	Insit T		b		avana at	١.				1	450135
	be executed icien end burial-transit	Sequentially list conditions, if any, leading to immediate		e to (or as a conse	equenca or	. 1	0 0				
68760	D Arie B		c. Eval	ntage	rev	a	dere	ane		9	1448 Across
387	enricata be ling physicie e as the bu	resulting in death) Last	Du	e to (or as a conse	quance of	1 1-					
×			d. Die.l	retel u	vel	ulu	LA				y cass
Bo	e attand e for us										
0	d by the attand letached for us	Part II. Other significant conditions	contributing to death but r	ot resulting in the	undarlying	causa giv	ran in Part I.	23b	. Did tobacco u	ae contributa	to the cause of death?
P.0	ed by the detached								1 Yes 2	No 3 P	robably 4 Ninknown
	signed b									1	•
Records,	the lew requires to take has been signed page 2 should be d							24a.	Was an eutops: performed?		Were autopsy findings available prior to
0	s been 2 shoul					-					complation of cause of death?
E :	ata has								1 □ Yes 2 🖼	A.	1 ☐ Yes 2 ☐ No
-	certificata rector, pag	25. Wes case referred to medical					00 DI	10		JAC	707 2010
5	this certific ral director,		Hospital:	- F		Ott	or:	of Death (Check		Dan (8)	
o d			28a. Date of Injury	2 ☐ ER/Outpatie		NA	# LI Nui	sing Home 5	cribe how injury		icity)
5	After funer	1 Alatural 5 Pending	(Month, Day Y	ear) Injury	M	28c. Inju			cribe now injury	occurred.	
Sic	Anenging r death. ector: Afte by the fune	2 Accident Invastigation 3 Suicide 6 Could not be					Yes 2 N				10-1-11-1
Division	Ti by	4 Homicide determined		- At home, ferm, s Specify)	treet, facto	ory, offica		City	or Town, State)	Number or H	ural Routa Number,
0	tal or Attending Pris after death. al Director: After led in by the funara Certification:										
	cal cal	29a. Certifier Certifying Pl									
	plete plet	one) and manner stated.									3 10 110 00000(0)
	To the hospital or Attenty within 24 hours after destroy to the Funeral Director: completely filled in by the Medical Certifical										
		D46020								6/5/0	0
		30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print)									
		Syed Ali, MD, 50				Mary	land 2	1601			
	Chata	31. Data filed (Month, Day, Yaar)	32. Registrar's		4	- MILY					
	State	IIIM O E		expedient	19	An-	11				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth . Month Year Doris Korers July 19 2000 4e. Facility Name (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death AIRHAVEN SYKESVILLE CARROL 7. Age (In yrs. lest birthday) 79 Yrs. If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth Pay, Year 1921 5. Social Sacurity Number 9. Birthplace (Stata or Foreign 1 □ M 2 XF Deys Hours 214-18-7290 Maryland Usuei Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 Yas 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21784 7200 Third Avenue U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No ff Yes, Give Yeer or Detas: 14. Race - American Indian, Bleck, Whita, atc. 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work dona duning most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Vernon Leroy Tydings Julia Margaret Tucholka 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. Thomas R. Tydings (nephew) 2719 Placid Avenue Baltimore, MD 21234 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriet 2 ☐ Cremetion 3 ☐ Removal from State Lorraine Park Mausoleum 7/22/2000 Baltimore, MD 4 Donetlon 5X Other (Spacify) Entonment 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410) – 23a. Part1. Entar tha disease, or complications that coused the death. Do not antar the mode of dying, such es cardiac or raspiratory arrest, ehock, or heert feilura. List only one cause on each line. Sykesville, MD 21784 (410)-795-1400 Approximata Onsel and Death Immediate Cause (Final ulmonary diseese or condition resulting in deeth) Due to (or es e consequenca of) Due to (or es a consequence of): 23b. Did tobacço use contribute to the cause of death? 18 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 ☐ Yes 2 XNo 1 ☐ Yas 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of

Physician /Medical Examiner sician end buriel-transit that the death certificate be executed

been signed by the attending physician should be detached for use es the burie

this certificate

After

To the Hospital or Attending within 24 hours efter death.

To the Funerel Director: After completaly filled in by the fune

funaral

filled in by tha

Physician/Medical

by

Completed

Certification:

Medical

Physician

/Medical

Examiner

MD

Director

Funeral

by

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Depentment of Health and Mentel hygiene. Important: If Item 27 is marked other than "natural", or thei any injury or other traumatic event, the Medical Examines.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital Attending Physicien:

with the Marylend

deeth

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Pert I.

1 Yes 2 No

27. Menner of Deeth 5 Pending investigation 123Naturei 2 Accident

6 Could not be

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29b. Signetura end titla of certifier

3 Sulcide

29e. Certifier

4 ☐ Homicide

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.
 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, and due to the cause(s) end mannar stated.

29c. License number

29d. Dete signed (Month, Day, Year) Third Avenue Sykesville MDZ1784

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Torrhand Formalien, 7200

State Registrar

31. Dete filed (Month, Dey, Year) 2 0 2000

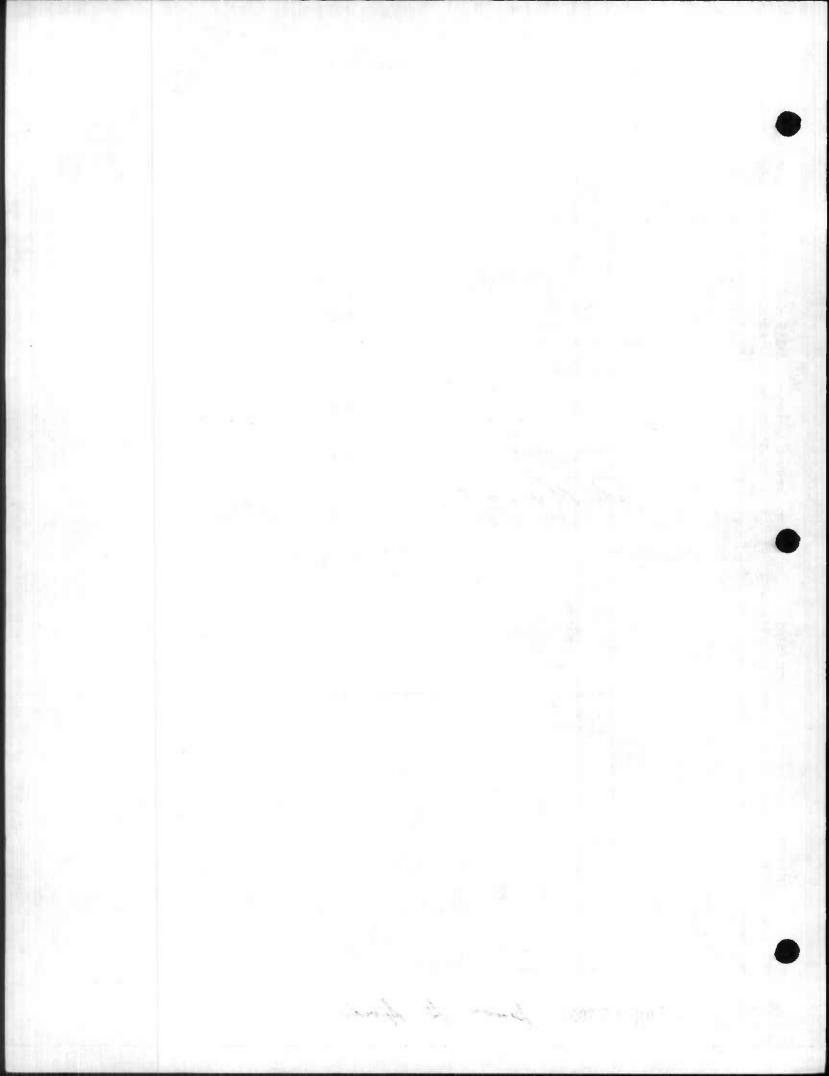


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State of Maryland / Department of Health and Mental Hygiene

			Otato of Mary		ate of Death	, ,	g. No.	24840			
		1. Decedent's Name (First, Middla, L.	nst)			2. Date of Death		3. Tima of Death			
e e	Physician /Medical	MABEL	С.	RU	SH	JULY 14	Day Yaar	1:50P.M.			
	Examiner	4a Facility Nama (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	4c. County of Death	1			
		ST. VINCENT I			FROSTB		ALLEGA	NY			
	Funeral		ADAM ARE	Mont	der 1 Year If Under 24 Hrs hs Days Hours Min		Year) 9. Birth	nplaca (Stata or Foreign untry)			
	Director	217-28-0562 Usual Rasidance of Decedent	8	5 Yrs.		Oct. 5	1914 MAR	YLAND			
	Du and	10a. Stata 10b. County	100	. City, Town or Location				10d. Inside City Limits			
	r 28a-f show undfilled at trector	Maryland GARI	RETT	FROST	BURG			1 Yas 2 No			
	notifie notifie	10e. Street and Number	(BII		Zip Coda	10	g. Citizen of What Cou	untry?			
	at be or	BEALL SCHOOL	ROAD		21532		U.S.A				
	funer open	11. Marital Status	12. Was Decedent Ever	in U,S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Maxican, Pual	Specify Yas or No-	14. Race - Aman Black, Whita				
21215-0020	by Exa	1 Nevar Married 2 Married	1 Yas 2 No If Yas, Giva Year or Dates:		s 2 No Specify:	no moan, atc.)		HITE			
5-0	natu disal	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's U	Isual Occupation work dona during most of wo	orkina 1	6b. Kind of Businass/Ir	ndustry			
121	oc within 72 ho ypiens. er than fratur t, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. DO NO	T use retired)						
7		17. Father's Nama (First, Middle, Las	0	SEA	MSTRESS	me (First, Middle, M	SHIRT F	ACTORY			
and	o Be	NOAH	*	NZIE	INEZ	inie (rirst, wilddie, w	MINNICK				
7	T T T	19e. Informent's Name/Relationship			ress (Street and Number or R	Purel Boide Number					
Ma	The Part	SHIRLEY BRANT									
re,	tem tem	20a. Mathod of Disposition		b. Place of Disposition (ALL SCHOOL		Oc. Location - City or T				
OH.	O H O	1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		CIMREDI AN	D CREMATORY	7/15/00	CHMPEDIA	ND MD			
Ħ.	injur 8	21. Signature of Funaral Service Lice			and Addrass of Facility						
œ i	SOUTH SE	John K	Alurst	57	EDOCE AVENU	URST FUI	NERAL HOM	IE P.A.			
		23a. Parts. Entar tha disease, or conspock, or heart failura. List only	plications that caused tha	death. Do not entar thain	FROST AVENU	ac or raspiratory arre	SURG, MD 2	Approximata			
P	hysician	shock, or heart failura. List only	one cause on each line.				1	Intarvat Between Onset end Death			
	/Medical	Immediata Causa (Final disaasa or condition	Intracto	ble Cong	estrio Hom	+ Inili	IPZ !	48 Hours			
E	Examiner	rasulting in death)	a. Dua	to (or as a consequence	estive Hear	Tarre	1	48 Hours			
	i i		CORONA	ARY ART	ery Diser	15E		3 weeks			
	physician and the burial-transit dical Examiner										
60,		Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	C								
68760,	physicia s the bur	that initiated events rasulting in death) Last	Due t	o (or as a consequence o	of):						
			d				1				
Вох	ed by the attending deteched for use of Physician/M					T					
0.	y the sched	Part It. Other significant conditions	contributing to death but not	resulting in the underlying	ig causa given in Part I.		./	to the cause of death? obably 4 Unknown			
D	signed b d be dett	Diabels	Wellelus				a ZUANO SUPR	Joseph 4 Olikilowii			
Records,	vequies the title beart centrolled been signed by the attendin should be deteched for use letted by Physician/M					24a. Was an		Vere eutopsy findings vailable prior to			
000	as been 2 shoul npiete					penon	C	complation of causa of death?			
						1 □ Ye	s 2 100 1	□Yas 2□ No			
	certificate rector, peg	25. Was casa referred to medical			26. Place of De	eeth (Check only one)				
>		examiner? 1 Yes 2 No	Hospital: 1 Inpatiant	2 ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Resider	nce 6 Othar (Spec	city)			
	after death. Director: After this in by the funeral dertification: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Tima of Injury	28c. Injury at Work?	28d. Describe hor	w injury occurred				
010	or death. Ctor: After by the fund	2 ☐ Accident invastigation		M	1 ☐ Yas 2 ☐ No						
Division	a ster death. I Director: After ted in by the funere Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Injury - / building, etc. (Sp	At home, farm, street, fac ecity)	tory, office	28f. Location (Str. City or Town,	eet and Number or Ru Stata)	ral Routa Number,			
0	Se de la company										
- 5	n 24 hours on Funeral I pletely filled	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	miner: On the basis of axan	knowledge, deeth occurr nination and/or investigat	ed et the tima, data and plac ion, in my opinion, deeth occ	e, end dua to the ca curred et the time, da	usa(s) end menner es te end plece, end due	stated. to the cause(s)			
4	within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification.	29b. Signature and title of certifier	and manner stated.		29c. License number	29	d. Dete signed (Month), Dey, Year)			
,	1.	11	nem D	14 8 40	D2563		29d. Dete signed (Month, Dey, Year) July 14, 2600				
	4	30. Nama and addrass of person who		(Hem 23a) (Tune Briss)	3~0)	0 1	ruy 17	1 4 000			
	nu	DR. CHANG S.		TBURG PLAZ	ZA FROSTRIII	RC MARV	LAND 215	32			
	State	31. Data filed (Month, Day, Year)	82. Registrer's S	ionature /		NG, PIANI	LAND ZIJ.	24			
	Registrar	JUL 1 7 2000	Denve	p spa	de						

DHMH 16 Ray 6/95



	6555	Decedent's Name (First, Middle, L.)	State of Ma		Certifica	ate of	Death	2. Date of De	Reg. No.	T.	3. Time of Death	
ш	Physician							Month	Day	Year		
45	/Medical	do Frankling Name (Manat in stitution -					4b. City, Town, or L	July ocation of Deet	13 4c. Count	2000 of Death	9:56 P.M.	
	Examiner	Sacred Heart Hos					Cumberla		Alle			
	Funeral	5. Sociel Security Number 6.	Sex 7. Age	(In yrs. last b	nirthday) If Un Monti	der 1 Year		8. Date of Bir	th	9. Birth	place (State or Foreign	
	Director	219-03-9935 Usual Residence of Decedent	1□ M 2√ F 8	3	Yrs.	ns Days	Nous Will.	October	5, 1916	West	Virginia	
napor Capor	in the	10a. State 10b. County		10c. City, To	wn or Location						10d. fnside City Limits	
N S	cto de c	MD Allegar	ly	Cuml	perland		201				1√ Yes 2 No	
death with the Mandand	al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	109 S. Smallwood	l St.			Zip Code 1502			U.S.A		ntry?	
		11. Meritel Status	12. Wes Decedent 8 Armed Forces?	Ever In U,S.	13. Was De	cedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No		14. Race - American Indian, Black, White, etc.		
5-0020	f, or he	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give X Year or Detes:	lo		s 2/2 No		7 110411, 0101)		Specify: White		
2 2		15. Decedent's E	Education	18	a. Decedent's U	sual Occu	upation during most of work		16b. Kind of 8			
21215-0020	h and Mental Hygiene. T is marked other than "nature traumatic event, the Medical Traumatic event, the Medical To Be Completed	(Specify only highest g	rade completed) College (1-4or 5	4)	Give kind of life. DO NO Sales C	T use retin	ed) most of work			ng/Shoes		
- 2	Hygie ant, m	17. Father's Name (First, Middle, Las	<i>t</i>)		Jaich C.	TOTIX	18. Mother's Nam	a (First Middle			.000	
S 2	marked other marked other matic event, To Be Co						Laura P			,		
aryla	ond N	19a. Informent's Name/Relationship	(Type, Print)	19	b. Mailing Addr	ess (Stree	et and Number or Ru	rel Route Numb	er, City or Town	, State, Zip	Code)	
	Health em 27 li	Willis M. Rice/Hu	isband	10	09 S. SI	mallw	wood St.	Cumberl	cumberland, MD 21502			
ore .	500	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Domeyal from State	camet	of Disposition (or other pla	ace)	Dete				
Pages	ury o	4 Donetion 5 Other (Spec	ify)	Cumbe	erland C	rema	tory 7	/15/00	00 Cumberland, MD			
Salt	Department Important: If any Injury or phose.	21. Signature of Funeral Service Lice	nsee				ress of Facility	D				
11 8	20229	S. Mark S	Me		Upch	urch	Funeral H	lome, P.	A. d. MD	21502		
		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	nplications that caused y one cause on each lin	the deeth. Do	not enter the n	node of dy	ring, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between	
	hysician Medical				. 1						Onset and Death	
	xaminer	Immediate Cause (Final disease or condition resulting in death)	a_ M	yours	leil.	infe	relem			- 1	Iday.	
	a		1	Que to (or as a	e consequence	diff						
Table 1	ansit Miner		D. 4	Mu	iselle	on a	4			-	10 years	
, ame	in and ial-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		one to for an a	x consequence	OI).						
5875U,	g physician and es the bunal-transit	Cause (Disease or Injury thet initiated events	c .	Due to (or as a	consequence (of):						
	d by the attending physicis letached for use as the build Physiciar/Medical	resulting in death) Last	d	west general co			3504					
Box	attendir of for use	Dod II Other classificant conditions	contribution to double by	it mat sa auttina	In the conduction		iven in Post I	22h Did	tobacco use or	antribute t	to the cause of death?	
	isigned by the a lid be detached f	Pert II. Other significant conditions	contributing to death bu	it not resuming	in the underlyii	ig cause g	iven in Part I.		Yee 2 No		bably 4 Unknown	
, the	igned to be detailed by P	Implyses	~						250,10	0_110	, to the total of	
Hecords, P.O.	shou							24a. Was	an autopsy ormed?	av	Vere autopsy findings vallable prior to completion of cause	
	this certificate has ral director, page 2 : To Be Comp							10	Yes 212No		death?	
	actor, pa	25. Was case referred to medical					26. Place of Dea					
	I direct		Hospital: 1 Inpatie	nt 2 ERVC	Outpatient 3	DOA O	thar		idenca 6 □Ot	her (Speci	ity)	
	h. After th funeral	27. Manner of Death 1 KNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b	. Time of Injury	28c. Inj	ury at ork?	28d. Describe	how injury occu	rred		
VISION	ector: After by the fune Iffication	2 Accident investigation	on		М		Yes 2□No					
5 6	at Director: After the in by the funeration:	3 Suicide 6 Could not determine		iry - At home, (Specify)	farm, street, fac	ctory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospital			hysician: To the best o									
2	within 24 hou To the Fune completely fi		and menner sta				Spiritori, doubli occul					
To the	5 5 2	29b. Signature end title of putifier				200 11-	nse number		29d. Date sign		Day Vand	

29b. Signature end title of patifie

29c. License number 2532 29d. Date signed (Month, Day, Year) 7-14-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Breza. M.D.
31. Date filed (Month, Dev. Year)
JUL 1 7 2000

912 Seton Drive 32. Registrar's Signature

Cumberalnd, MD 21502

DHMH 16 Rev 6/95

25

res

State Registrar

Division of Vital Records,

17 200 2

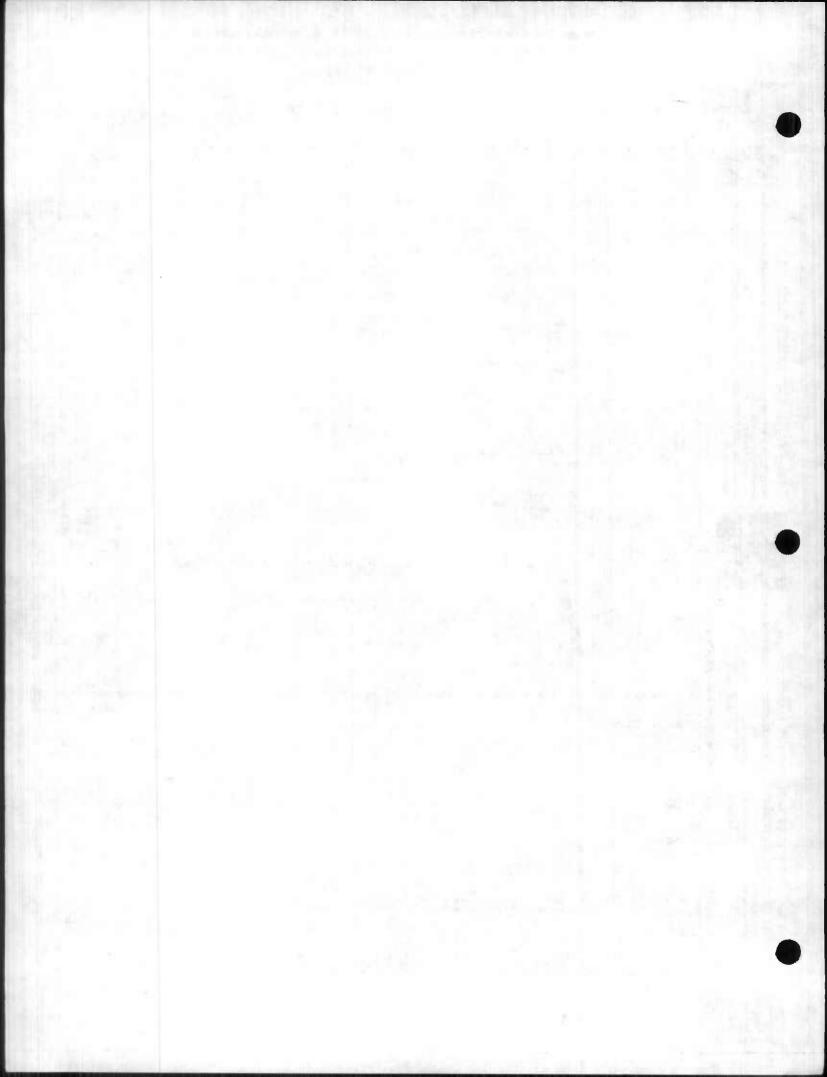
	-	\sim	5
State of Maryland / Department of Health and Mental Hygiene	JI	U	

amend item 1 per phys. G786 8/7/00 yg Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) JULIA ANN RAILEY 2. Date of Death 3. Tima of Death Month **Physician** JUL 2000 08:00AM Ann 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner timore lity 102 onns Baltimore MOP If Under 1 Year If Undar 24 Hrs 7. Age (In yrs. last birthday) 8. Data of Birth Birthplaca (Stata or Foraign Country) **Funeral** Days Min 1□M 2\ F Yrs Director 212-54-8557 46 Maryland Usual Residence of Dacedanl 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov iene. - than "natural", or itema 23a or 28a-f sho: the Medical Examiner must be notified at 14 Yes 2 No Directo Garrett Mt. Lake. Park 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 108 A. St. Apt# 106 21550 U.S.A. Funeral 14. Race - American Indian, Black, Whila, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) filed within 72 hours after 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0020 þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 + Housewife Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be should be and Mental is merked Wade Edwin Janoske Eleanor 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 at Department of Health and Important; If hen 27 is in any Injury or other traum once. 2902 George Washington Highway, Oakland, MD 21550 ce of Disposition (Nama of Date 20c. Location - City or Town, Stata Ruth E. Janoske/ Mother Saltimore, 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Red House Cemetery 7/4/00 Oakland, MD 22. Nama and Addrass of Facility Stewart Funeral Home Sowood 32 South Second Street, Oakland, MD 21550 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Daath Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 30 DAYS Examiner Dua to (or as a consequence of Physician/Medical Examine ER The law requires that the death certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, laeding to immediata cause. Enter Undarlying Cause (Disaasa or Injury Dua to (or as a consequence of) Box 68760. that initiated evants resulting in death) Last Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of ceusa of death? pital or Attending Physician: The law ours after death.

eral Director: After this certificate has titlled in by the funeral director, page 2 s 1 ☐ Yas 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Piaca of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Hospital: 1 Yas 2 No Certification: To Inpatiant 2□ER/Outpatient 3□ DOA 27. Manger of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Investigation Netural 1 Yas 2 No 2 Accidant 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Phyeician: To the best of my knowledga, death occurred et the time, dete and place, and due to the cause(s) end mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and mannar steted. edicai 29e. Certifiar (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier RES-001 JULY 01, 2000 30. Name and addrass of person who complated cause of daath (Itam 23a) (Type, Print) 600 N. WOLFE ST. J3ALTIMORE MD 2128 SAN JOHNS HOPKINS ANI 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JUL = \$ 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate	of L	Death			Reg. No.		
Physician	1. Decedent's Name (First, Middle, I Clara Ruth RID)							2. Date of De	Dayn /	2000	3. Time of Death
/Medical Examiner	4a Facility Name (If not Institution, g Washington Cour				4		wn, or Lo	cation of Dawl	4c. County		gton
Funeral Director	5. Social Security Number 6. 217–10–3122	Sex 7. A 1□ M 2□ F	ge (In yrs. last birthda 86 Yrs.	y) If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da May 8,	h y, Year) 1914	9. Birthpl Coun Pen	lace (State or Fore
f show fied at tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washir	naton	10c. City, Town or	Location agers to	wn					11	0d. Inside City Lim
Sa or 28a-fe it be notified il Directo	10e. Street and Number 1215 Glenwood A		EWE	10f. Zip C	_	2	21742		10g. Citizen of V		try?
at, or hams 2 Examiner mu by Funers	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 217 If Yes, Give Year or Dates:		3. Was Deceder If Yes, specify 1 \(\text{Yes} \) 2 \(\text{L} \)		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	14. Rac Blac Specify	ce - America ck, White, o	
or than 'nature, the Medical.	15. Decedent's (Specify only highest g	Education grade completed) College (1-4or	(Gi life	cedent's Usual (ve kind of work DO NOT use	done d retired,	luring mos)		ing	16b. Kind of Bu		
B son	8 17. Father's Name (First, Middle, La Grover Cleveland		asse	mbly li	ne :		er's Name	e (First, Middle,	par Maiden Suman	ets m	fg•
th and Men 7 is marks traumatic	19a. Informant's Name/Relationship Vicki S. Frick -			-			er or Aure	ai Route Numbe	er, City or Town,		Code) d. 21740
ent of Heal at: If Item 2 y or other	20a. Method of Disposition 1	☐Removal from State	20b. Place of Dis	position (Name rematory or other	of or place	9)	1	Date	20c. Location -	City or To	
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SALLY ANN SKIDMORE 16, 2000 11:45A JULY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Yrs. 214 36 6547 MARYLAND 61 OCT 28 1938 Director Usual Residence of Decedent r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MARYLAND ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code wither man be n 18507 OLD TROUTMAN'S LANE, SW 21532 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be I and 2 should be fit Health end Mental F MELVIN CUTHBERTSON BERNADINE KENNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) LEROY L. SKIDMORE / HUSBAND 18507 OLD TROUTMAN'S LANE, SW, FROSTBURG, MD 21532 Department of Healt Important: If Item 2 any injury or other other. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Pages nent of P 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State FROSTBURG, MD 7/19/00 4 ☐ Donetion 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 22. Name end Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last physician s the burial Box 68760 Dua to (or as a consequenca of): 8 use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown disca by Records, 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Be Completed 2 No 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physicien: 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□Mo Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Neturel 5 Pending investigation 1 Yes 2 No aftar death. 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a Certifier Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number FACP JULY 16,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

1 8 2000

DHMH 16 Rev 6/95

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32. Registrar's Signat

925 Bishop walsh RD Cumbuland,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician PEARL AGNES 19 2000 SHUPP JULY 4:10 A.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JULIA MANOR HEALTH CARE CENTER HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2X F 87 APRIL 19, Director 217-42-8844 MARYLAND Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23s or 28s-f show 1 ☐ Yes 2 X No Director MARYLAND WASHINGTON CLEAR SPRING 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21722 13613 NATIONAL PIKE Funeral U.S.A. death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b: Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 end 2 should be fill ment of Health end Mental Hant: If Hem 27 is merked oth jury or other traumatic even Be AARON BIRDINARY DeLAUNEY ELNORA VIRGINIA GROVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) HARRIET L. THOMPSON/DAUGHTER 13613 NATIONAL PIKE, CLEAR SPRING, MARYLAND 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department o Important: If I any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) REST HAVEN CEMETERY 7/24/00 HAGERSTOWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 7606 Old National Pike BAST FUNERAL HOME P. Steven Danfelt Jr. Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** O(ARDIAL INTA /Medical Immediate Cause (Final disease or condition resulting in death) Op, Examiner Examiner sician and buriel-transit the death certificate be executed Sequantially list conditions, if any, laeding to immediate cause. Enter Undarlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or es a consequence of): physician s the buriel Box 68760, Physician/Medical Due to (or es a consequence of): USe 23h. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 108 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 DN0 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in Hospital 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

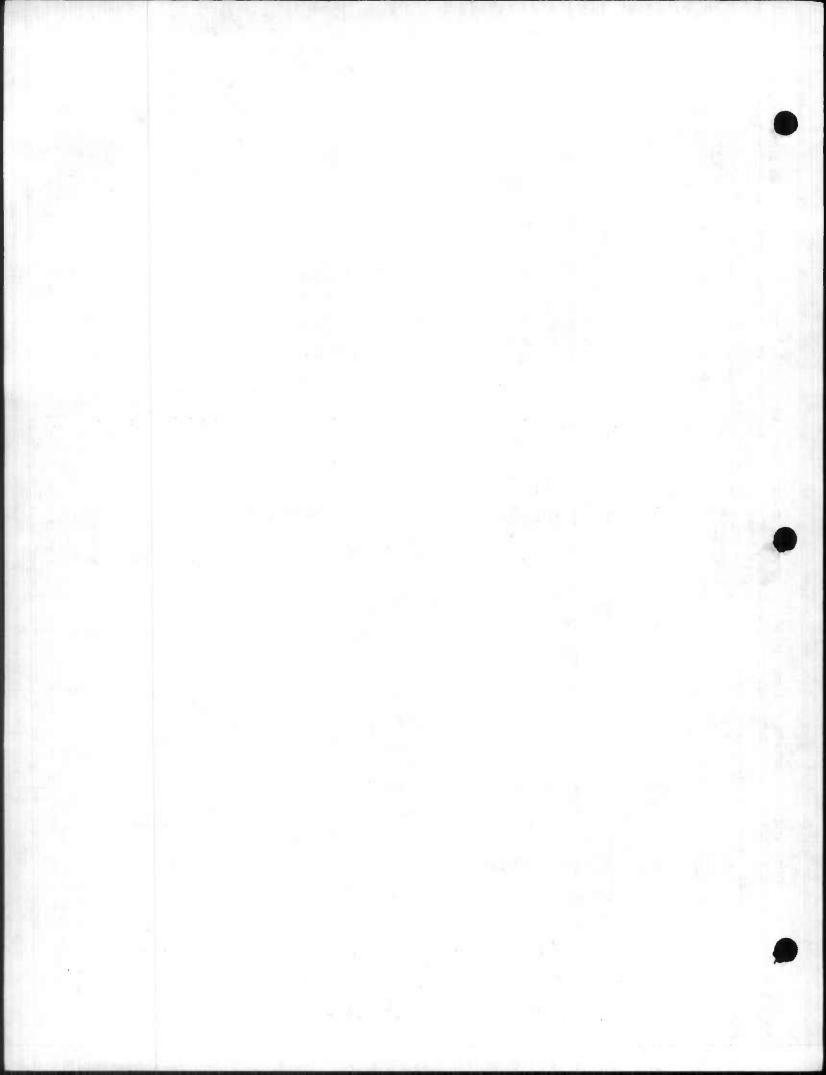
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of parson who com pleted cause of deeth (Item 23a) (Type, Print) rebex (Apply 20) HAGEILFTOWN DIU 11110 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

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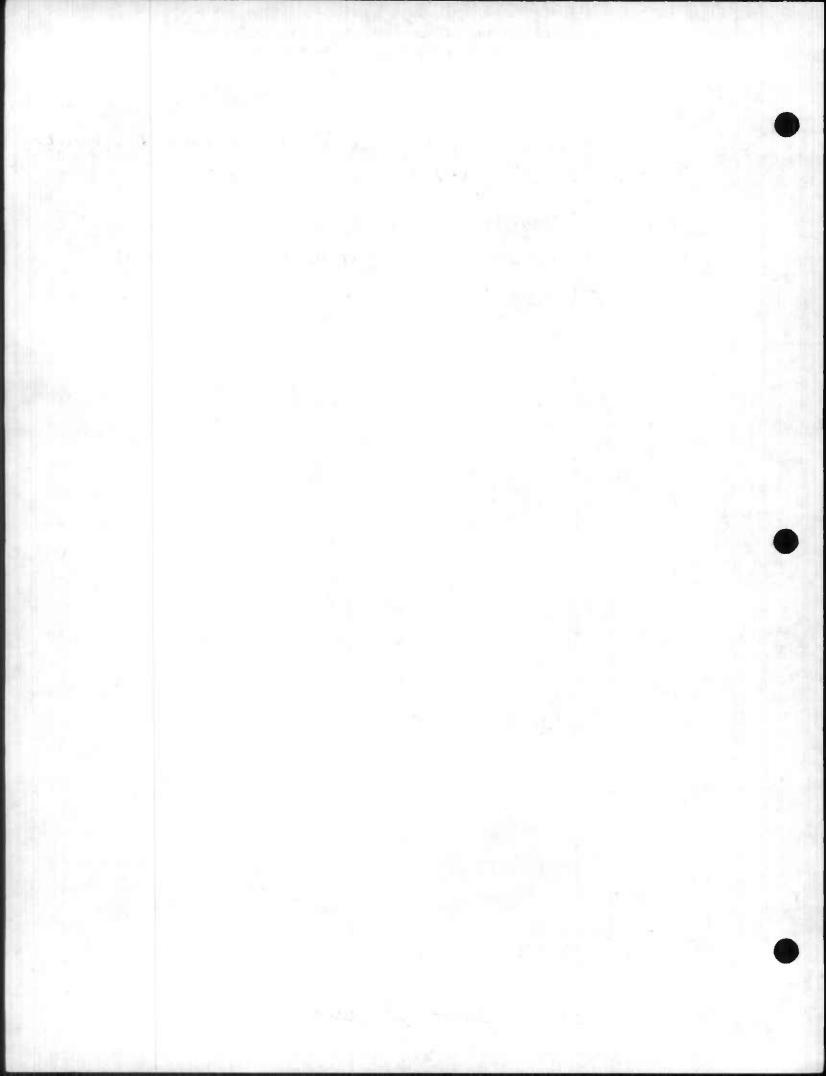
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	Certificate of Death	Reg. No.	00 2404/
Physician	1. Decedent's Name (First, Middle, Last) Status Colon Shares	2. Date of Death Month Day	Year 3. Tima of Death
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death 4c. Cou	anty of Death
Cxammer	Washington Co. Hospital - 88 Hage	stown.mo	bashington
Funeral Director	220-26-558 69 Yrs.	frs. 8. Date of Birth (Month, Day, Year) 9/25/30	9. Birthplaca (State Foreign Country) Maryland
P 8	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Manyl 4 sho led a	MO 400 Shinaton Honers town		1 1 → Yes 2 □ No
with the Ma t or 28e-f a be notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen	of What Country?
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Ball permit Depart Import eny in	21. Signature of Lineral Service Licenses 22. Name and Address of Facility Donald Edwin T	hompson Fune	ral Home, Inc
	POBOX 310 CI 23a and Fine the disease or complications that caused the death. Do not enter the mode of dying, such as card and complete the mode of dying, such as card	ear Spring,	MD 21 722 Approximate Interval Between
Physician			Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition		14 days
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cord requir been s should		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
The lay page 2		1□ Yes 2NN	o 1 Yes 2 No
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Of Vita Physician: this centificated director.	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	g Home 5 Residenca 6 D	Other (Specify)
On O ding Ph h. After th funeral	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury oc	curred
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Division Tor Attending after death. Director: After d in by the fune ertification	4 Homicide determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State)	uniber of Adrai Addie Number,
Hospita 4 hours Funeral tely filled	29a. Certifier (Check only one) Check only one) Check only one) (Check only one) (Check only one) Check only one) (Check only one)	aca, and due to the cause(s) and courred at the time, date and pla	I manner as stated. ce, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of cellifier 29c. License number	29d. Date si	gned (Month, Day, Year)
- 3 - 0	Dub Dub	473 71	20/00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		21740
	Hind Hamdan, MD; 363 S. Clevelane	HAG: HOLD	am nuotars
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature Seneral Suchs	, 0	
Registrar	JUL 2 1 2000 Dener & sparks		



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Lerou July 19, 2000 6:08 p.m. 4e Facility Neme (ff not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deeth Hagerstown 910 Armstrong Avenue Washington If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept. 10 1914 7. Age (In yrs. last birthday) Deys 1⊠M 2□ F Yrs. 85 Maryland 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 21740 USA 910 Armstrong Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1∑1 Yes 2 □ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Med. Lab Tech. Government Unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme)

Blanche Haupt

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Keedysville, Md. 21756

20c. Location - City or Town, Stete

10a. State Director Maryland 10e. Street and Number Funeral þ Completed Elementery/Secondary (0-12) Be Clarence Sisk 19e. Informent's Neme/Reletionship (Type, Print) Michael R. Sisk - Son

Physician

/Medical

Examiner

Funeral

Director

Eldred

10b. County

5. Social Security Number

214-09-4817

Usuel Residence of Decedent

3 ☑ Widowed 4 ☐ Divorced

Unknown

20e. Method of Disposition

Physician /Medical Examiner

as the 6 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica ours after death.

eral Diractor: After this certified filled in by the funeral director,

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

1 ☐XBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		ose Hill Ceme		7/22/00 Hagerst	own, Maryland
21. Signature of Funeral Service Licen			Address of Facility	MINNICH FUNERA	
Scott	W Muy	415 E.	Wilson Blvd	l., Hagerstown,	
23a. Pert1. Enter the disease, or com shock, or heart feilure. List only	blicetions that caused the decone cause on each line.	eth. or not enter the mode	of dying, such es cardia	c or respiretory errest,	Approximate Intervel Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	Len	al Cell	Curcinon	• 4	
resulting in death)		(or es e consequenca of):			
Sequentially list conditions, if eny, leading to immediate	b. Due to	(or es e consequence of):			
cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last	c. Due to	(or es e consequence of):			1
	d				
Pert II. Other significant conditions of	potributing to death but not re	sculting in the underlying of	use given in Pert I	23h Did tohacco use co	ntributs to the cause of death
Total agricultural conditions	Simboling to doubt but not re	southing in the underlying co	oso given in r orci.	1 □ Yee 2 No	3 Probably 4 Unknow
				24a. Wes en eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
				1 ☐ Yes 2 No	1 Yes 2 No
25. Was case referred to medical	and service in the		26. Place of De	ath (Check only one)	
examiner?	Hospitel: 1 Inpatient 2[☐ ER/Outpatient 3☐ DO	A Other: 4 Nursing I	fome 5 Pesidenca 6 □Oth	ner (Specify)
27. Menner of Death 1 Netural 5 Pending 2 Accident investigation		28b. Time of Injury M	Bc. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, street, fectory,	office	28f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,
29e. Certifier 12 Certifying Ph					
(Check only 2 Medical Exam	ysician: To the best of my kn liner: On the besis of examin end menner steted.	nowledge, deeth occurred enetion and/or investigation,	t the time, date end plece in my opinion, deeth occu	s, end due to the cause(s) and ma urred et the time, dete end place,	anner as stated. and due to the ceuse(s)

son Blud. Smithsburg, md

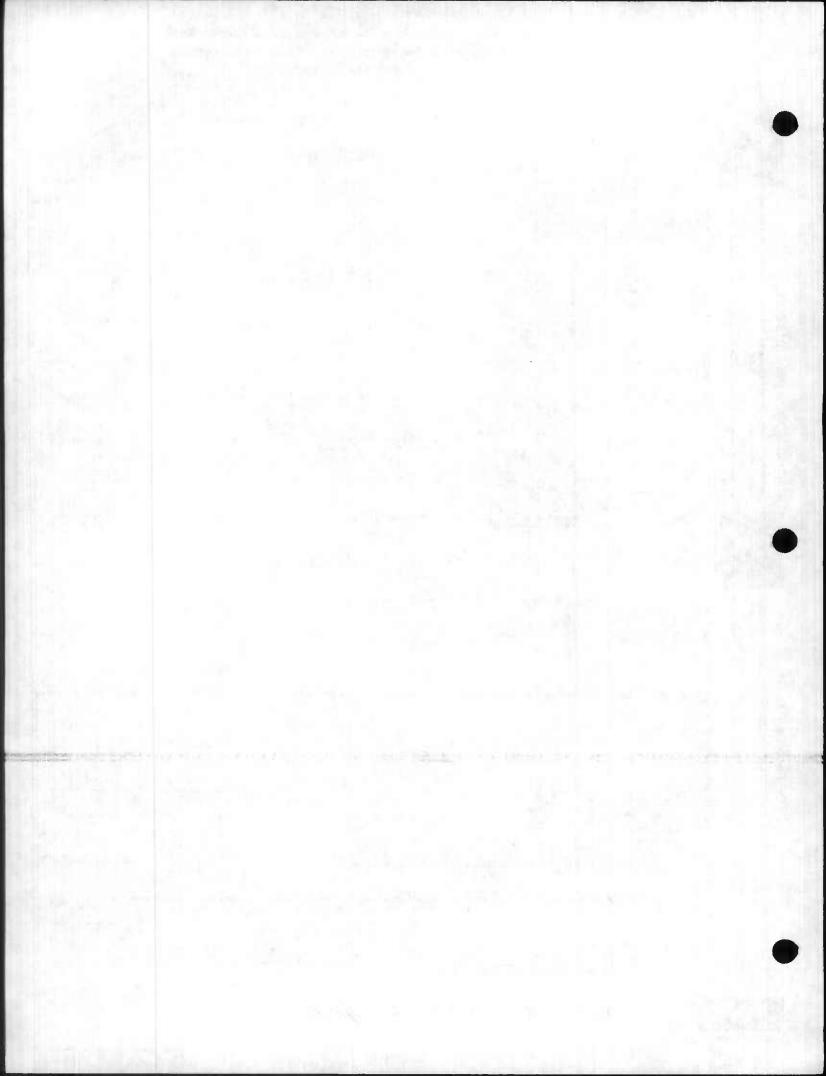
19348 Dogstreet Road

20b. Plece of Disposition (Neme of cemetery, cramatory or other place)

completaly

State Registrar

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

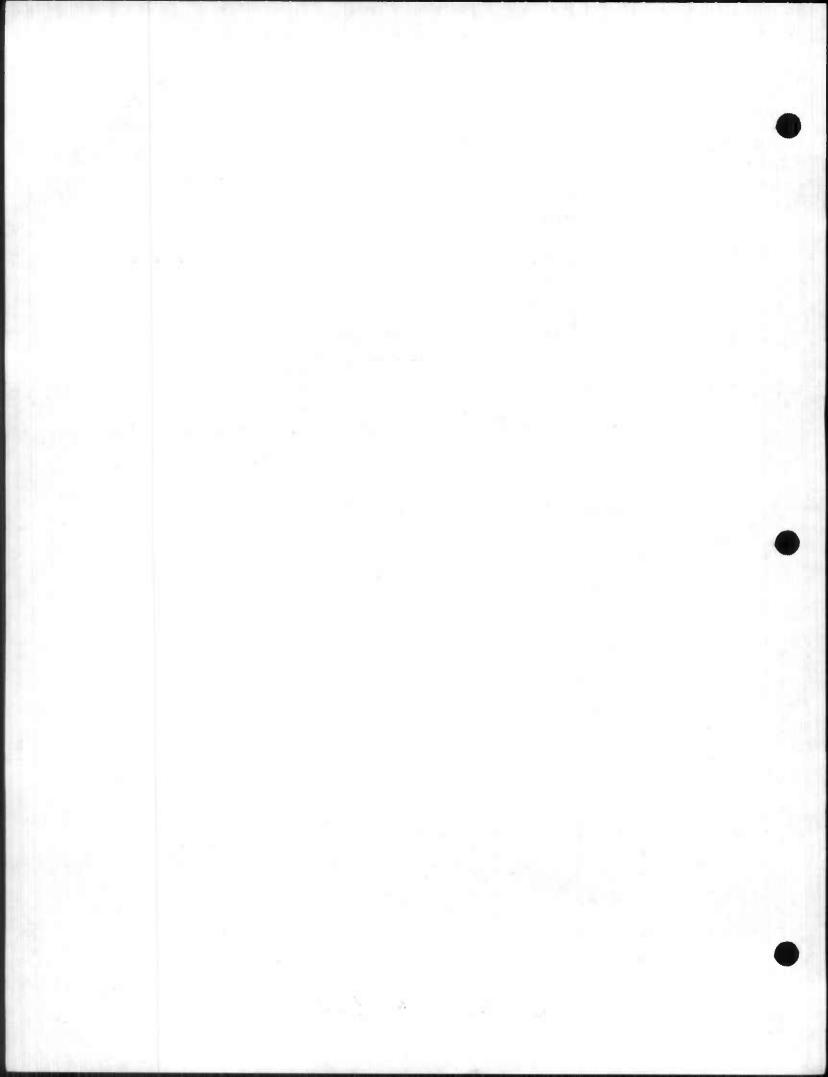


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Anna Aileen Stottlemyer Stouffer State of Maryland / Department of Health and Mental Hygiene

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sen ste	ottranyer Stourre			Certifica	ate of	Death		Reg. No.	00	2404
	. Decedent's Name (First, Middle, La	st)					2. Dete of De Month	ath Day	Year	3. Time of Deatl
ysician Medical	Anna Aileen S	tottlemyer	Stou	ffer			July	07 2		10:00 A.
	e Facility Name (If not institution, giv	e street end number)				4b. City, Town, or		4c. County	of Deeth	
	Old Forge Road					Hagers			ington	
	Social Security Number 6. S 217-12-2757 July Residence of Decedent	M 20XF	75	Yrs. Month	der 1 Yeer ns Deys	If Under 24 Hrs Hours Min		lh ly, Year) 3, 1924	9. Birthple Country Mary 1	ce (Stete or Fore y) Land
-	Oa. Stete 10b. County		10c. City, To	own or Location					100	d. inside City Lim
tor	MD Washingt	on	Hage	erstown						1 N Yes 2 □
ā	Oe. Street and Number 411 East Irvin A	ve.			Zip Code 21742			10g. Citizen of U. S.		n
by Fur	1. Merital Stetus 1 Never Married 2 Merried 3 M Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:				tispanic Origin? (s an, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	Bla	ca - American ck, White, etc y: White	c.
Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5	+}			pation during most of wo	orking	16b. Kind of B		
5	12	-	F	ccounti	ng Cl		450 - 440-4-4	Privat		stry
m	7. Father's Name (First, Middle, Last,						me (First, Middle		ne)	
2	Charles Edger St						earl Har			
	19a. Informant's Name/Relationship (Barbara L. Ridenc	Type, Print) Siste	r-in 1	9b. Mailing Addr	ess (Streat	and Number or R	lure! Route Numb	er, City or Town	, State, Zip C	ode)
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2	12 Burial 2 Cremetion 3 C			of Disposition (// tery, cremetory of Haven C			7-11-00			
-	4 ☐ Donetion 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Kest			ss of Facility	7-11-00	magerst	OWII, P.	ш
	23a. P	May		1601	Penn	sylvania	est Have Ave. F	lagersto		•
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edical	Sequentially list conditions, fory, leading to immediate cause. Enfer Underlying Cause (Disease or injury hat initiated events resulting in death) Lest	c		e consequence o						
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	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)		
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edicai Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injubulding, etc	ry - At home, . (Specify)	term, street, fac vehicle	tory, offica		City or To	Street end Num wn, State) 0]. :OWN , Ma	d Ford	re Road
dicai	29e. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on the basis of end manner sta	examinetion	ge, death occurr and/or investigat	ed at the til ion, in my o	me, date and place opinion, death occ	e, end due to the curred et the time,	ceuse(s) and m date end place,	anner es ste and due to t	ted. he cause(s)
	29b. Signeture end title of certifier				29c. Licens	se number		29d. Date signe	ed (Month, D	ay, Year)
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3	O. Name end address of person who Theodore King M.		eth (Item 23a		Penn	Street,	Baltimor	e, Marv	land 2	21201
State 3	11. Dete filed (Month, Day, Year)	32. Registre	r's Signature	4	Low					



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State of Maryland / Department of Health and Mental Hygiene

lental Hygiene

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	5. Social Securit	al Hosp	6. Sex	7 A	ge (In yrs. last b	nirthria v 1	If Under	r 1 Yeer	If Under						alece (State or E
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No.

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	Physician	CARLO	SCAR TURNER	2						23, 2000		2:34P.M.
10	/Medical							4b. City, Town, or I		1	ty of Death	2.34F.M.
<i>)</i> 1	Examiner	48 Facility Name	e (If not institution, give	street ena number)				4b. City, Town, or i	LOCATION OF DOG	4c. Cour	ty of Death	
		Memoria	1 Hospital	& Medical	CEnt	er		Cumberlan	nd	A1:	Legany	
E.	uneral	5. Sociel Securit			(In yrs. las	t birthday)	If Undar 1 Yaa		8. Date of Bi	rth	9. Birthp	lace (Stata or Foraign
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Me.	1 0	PA	Bedford	l	Buffe	rlo Mil	ees					1 ☐ Yes 2 ☒ No
e e	be noticed Director	10e. Street and I	Number				10f. Zip Code			10g. Citizen o	What Coun	try?
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£	r tems 23a or 28a-f show siner must be notified at Funeral Director	403 000	ve kouu							USA		
90	1 5	11. Marital Statu	IS	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Wa	is Decedent of	Hispanic Origin? (S ban, Mexican, Puart	pecify Yes or N	0- 14. Ri	ica - Amaric ack, White,	
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3.10

State Registrar

CHRUSTINE

Beauty Signatura

c MD

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

Sparks

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 24853 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Month Year **Physician** 11:08 AM Viola Maude Woodward 4b. City, Town, or Location of Death 18, 2000 4c. County of Deeth /Medical 4e Fecility Neme (If not institution, give street end number) Examiner Golden Age Guest Home Sykesville Carroll 8. Dete of Birth (Month, Dey, Year)
Aliq. 2, 1908 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 91 219 14 8774 Director Md Usuel Residence of Decedent the Maryland 10b Counts 10c. City, Town or Location 10d Inside City Limits 23a or 28a-f ahow the Medical Examiner must be nothing at Md. Carroll Director Sykesville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f Zip Code 10a, Citizen of What Country? deeth with 1442 Buckhorn Road 21784 U.S.A. Funeral 14. Race - American Indien, Bleck, White, etc. Rems : Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If Nem 27 is marked other than "natural", or iter any injury or other traumatic event, tra Medical Examina 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Henry Clinton Bloom Maude G. Ecker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Intorment's Name/Reletionship (Type, Print) Grace Graham (Niece) 9891 Baltimore Nat. Pike Ellicott City 21042 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Popular Spring Cemetery 7/21/00 Lisbon, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Haight Funeral Home & Box 195 Sykesville, Chapel Md. 21784 0. tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23e. Pert1. Enter Approximete Intervel Between Onset end Deeth **Physician** Segretter /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es consequence of) Examiner sician end The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burial P.O. Box 68760 Physician/Medical Due to (or es e consequenca ot) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yss 2 No 3 Probably 4 Unknown been signed be should be det Records, à 24b. Were eutopsy tindings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 2 No 1 Yes 1 Yes 2 No Division of Vitai or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturel death. 1 Yes 2 No investigation 2 Accident aftar deatl 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify)

• Funeral E Hospital To the I

> State Registrar

DHMH 16 Ray 6/95

filled in by

4 Homicide

(Check only one)

29b. Signature and alle of codilie

31. Dete filed (Month, Dey, Year)

29a. Certifier

2 0 2000

Julesu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s)

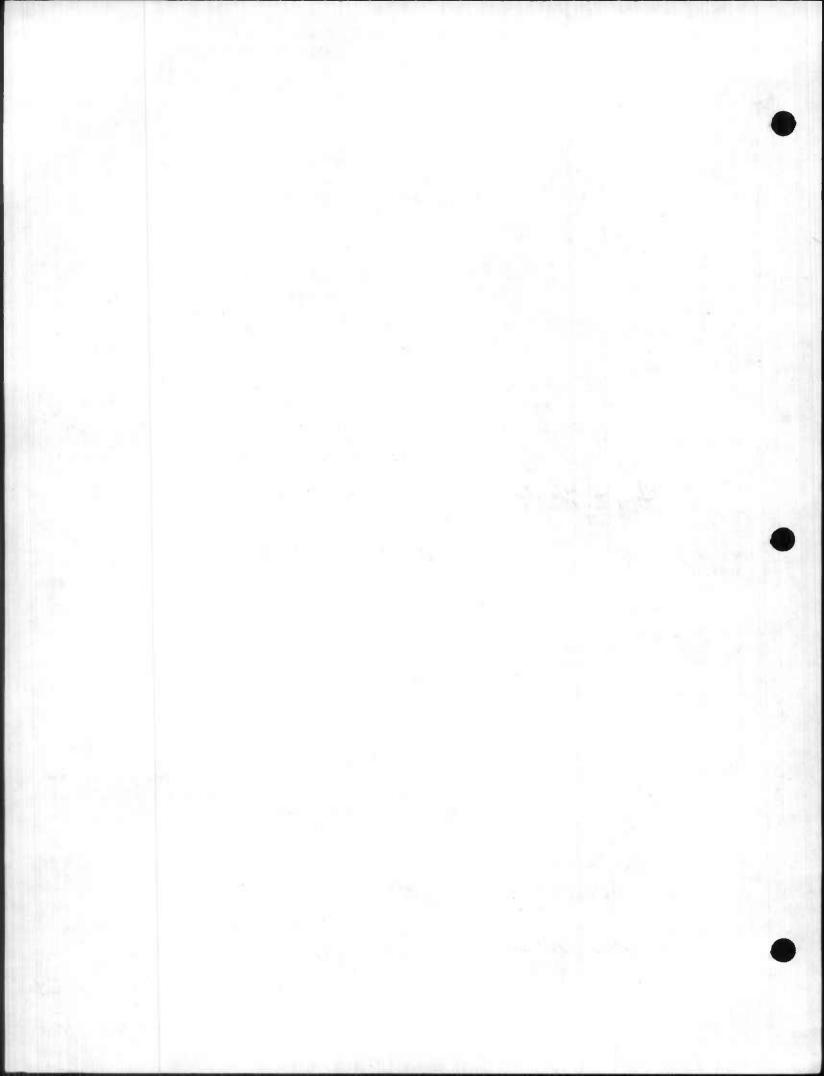
29c. License number

20806

29d. Date signed (Month, Dey, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 24854

Carl Examiner Medical Examiner Be notified at Examiner Be notified at Examiner Be notified at Examiner Briefled by Funeral Director	4a Facility Name (If not institution, given in the institution in the	harton ve street and number) Maryland 1				2. Dete of Des Month	ith	3. Tima of De
/Medical Examiner Funeral Director	4a Facility Name (If not institution, given in the institution in the	Maryland / Sex 7. Age				-	Day	Veer
Examiner Funeral Director	5. Social Security Number 6. S. 215 - 20 - 6629 Usual Residence of Decedent 10a. State 10b. County	Maryland / Sex 7. Age				July	1.0	000 16:05
Funeral Director	5. Social Security Number 6. S. 215 - 20 - 6629 Usual Residence of Decedent 10a. State 10b. County	Maryland / Sex 7. Age			4b. City, Town, or	Location of Death	4c. County o	
Director	S. Social Security Number 215 - 20 - 6629 Usual Residence of Decedent 10a. State 10b. County	Sex 7. Age		1.040	0 1			
Director	215 - 20 - 6629 Usual Residence of Decedent 10a. State 10b. County				Baltimo			
	Usual Residence of Decedent 10a. State 10b. County		(In yrs. last birthday)		ays Hours Min		Year) 925	9. Birthplace (State or Fi
23a or 28a-f show unit be notified at al Director	10a. State 10b. County		75 Yrs.			Mai 11	, 1525	1-112
23a or 28a-f show ust be notified at	1.50							
23e or 28e-f s uet be notified al Director	MD Alle	15.5	10c. City, Town or Lo					10d. Inside City I
23a or 28a unit be not al Direc		gany	Cun	nberla	nd			1 XYes 2
23a or	10e. Street and Number			10f. Zip Co	de		10g. Citizen of Wh	hat Country?
23 60	123 Gleason S	treet			21502	100	USA	
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r heme 23 alrer must Funeral	11. Marital Status	12. Was Decedent E Armed Force ? 1 Yes 2 N	Ver in U.S. 13.	If Yes, specify	t of Hispanic Origin? (5 Cuban, Mexican, Pue	rto Rican, etc.)	Black	, White, etc.
Y F		If Yes, Give	0	1□ Yes 2□	No Specify:		Specifika	white
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	Hementery/Secondery (0-12)	College (1-4or 5-	h amon	DO NOT use n	fone during most of wo etired)		area base	
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le u	WI TITAM E. Wha	reon"	501	Bastr	treet and Number or F	ale, MD.	21502	stere, Zip Code)
of Health end Mer Hem 27 Is marks other traumatic	son							
	20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name o	of r place)	Date	20c. Location - C	City or Town, State
nent of I nt: If Its iry or o	1 Burial 2 Cremation 3 4 Donation 5 Other (Specif				rial Gard	17/22/	LaVale,	MD
	21. Signature of Funeral-Service Licer				des of Fune			1.10
Depenting Imports any injury i	21. Signature of Pullera Pervice Elcer	1	/ / /	-				
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	23a. Part1. Enter the diseese, or com shock, or haert feilure. List only	plications that caused	the death. Do not en	nter the mode of	dying, such as cardin	c or respiratory ar	rest,	Approximate intervel Between
hysician	Shook, of healt fallate. Elst only	9110 00000 011 00011 1111						Onset and Dec
Medical	Immediate Ceuse (Final	1	1					
xaminer	disease or condition resulting in death)	a. Lung	Cancer					1
5			Due to (or as a conse	quence of):				
in and fal-transit Examiner		b. Post	preumone	ectomy	Respira	tory fo	ilure	
ding physician and se es the burial-transit Medical Examil	Sequentially list conditions,	(Due to (or as a conse	quence of): 0				
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Part Part	resulting in death) Last	1. 10	Renal F	- ~/				
ed for use sician/M		d. Meure	Kenal F	-aulun	2			
for for Class								
0 0	Part II. Other significant conditions of	contributing to death but	t not resulting in the u	underlying caus	e given in Part I.	23b. Did t	obacco uss cont	tribute to the cause of c
Ph Ph						1,021	res 2 No	3 Probably 4 □ Un
signed if								
ate has been signed by the page 2 should be detache?							an autopsy med?	24b. Were autopsy find available prior to
should should						perio	illedi	completion of cau of death?
page 2 should								
page Com						1,23,1	'es 2□No	1 ☐ Yes 2 M No
= 5 0						eth (Check only o	ne)	
Be Be	25. Was case referred to medical exeminer?	Hospitel: Inpatier	nt 2 ER/Outpatie	ent 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	lence 6 Othe	r (Specify)
0 = 0			y 28b. Time of Injury	of 28c.	Injury at Work?	28d. Describe h	now injury occurre	bd
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or death. Store: After this by the funeral di Ification: To	exeminer? 1 Yes 27 Menner of Death 1 Mentural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Plece of Injubuilding, etc. 28e. The best of miner. On the basis of and manner state	f my knowledge, deet examination and/or in ted.	29c. Li	my opinion, death occ	curred at the time,	dete and place, a	(Month, Day, Year)
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within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	exeminer? 1 Yes 27 Menner of Death 1 Mentural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Plece of Injubuilding, etc. 28e. Plece of Injubuilding, etc. hysician: To the best of miner: On the basis of and manner stat	f my knowledge, deet examination and/or inted.	29c. Li	my opinion, death occi	eurred at the time,	dete and place, at 29d. Date signed	(Month, Day, Year)

DHMH 16 Rev 6/95

once or all

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24855 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician JAMES WILLIAM WITT JR. 22 2000 JULY 11:10AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1♥M 2□F 215-26-6244 71 Director 11 1929 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show must be notified at ALLEGANY 1 ☐ Yes 2 ☐ No Director MARYLAND CUMBERLAND 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23s or 307 POLK STREET 21502 U.S.A. Funeral 14. Race - American Indian, 11 Marital Status Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 WHITE Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) VAN DRIVER/DELIVERY VAN DRIVER/BOARD OF EDUCATION 10 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if New 27 is marked other
any Injury or other trauments other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be JAMES WILLIAM WITT SR. DELTA LOUISE WINEBRENNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 POLK STREET CUMBERLAND MARYLAND JOANNE KOELKER COMPANION 20c. Location - City or Town, State RFD FLINTSTONE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND ROCKY GAP VETERANS CEMETERY JULY 25 2000 21. Signature of Funeral Service License 22. Neme end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. Leville ale ox 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ARTERIO SCLEROTIC HEART DISEASE UNKNOWN YEAR\$ Examiner Due to (or as a consequence of): Examiner physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): for use as 997 P.O. signed by the a d be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? pege 2 1 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division Attanding 1 Naturat 2 Accident 5 Pending investigation r death. 1 Yes 2 No we Hospital or Attandi n 24 hours aftar death. Ne Funeral Director: A bietely filled in by tha fo 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granyler stated. 29a. Certifier edical (Check only one) To the Within 2.
To the Foompiet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2

my

JUL 2 4 2000

DR PAUL SNOW

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

124 WEST 3rd STREET

& Sparker

D 09159

CUMBERLAND MARYLAND

JULY 22, 2000

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State of Maryland / Department of Health and Mental Hygiene

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	Examir		4a Fscility Name (f	f not institution, giv	re street and numbe	er)	4-1-4	4b. City, Town,	or Location of Dea	th 4c. County	of Death	
10					L & Medic			Cumbe	rland	Alle		
	Funeral Director		5. Social Security N 236 – 50 – 2	496	Sex 1□ MX2□ F	Age (In yrs. lest b	Yrs. If Under 1 Months	Yeer If Under 24 H Deys Hours M	Irs. 8. Date of Bin, (Month, D	nth (Year) 1933	9. Birthpla Countr M	nce (State or Foreign
	pue *-		Usual Residence of 10a. State	10b. County		10c. City, To	wn or Location				100	d. Inaide City Limits
	/aryli	Ö	Nineral Ridgeley								1 ☐ Yes 2 ☐ No	
	the 128a	rect	10e. Street and Nur		CC II	1	10f. Zip C	ode		10g. Citizen of W	hat Countr	21
	3a or		Rt. 1 Bo	x 140				26753		USA		
0	n 72 hours after death with the Maryland "natural", or flema 23a or 28a-f show edical Evantive: mar be notified	by Funeral Director	11. Merital Statua 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give		13. Was Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				tc.	
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P	tal Hygid d other event, ti	0	17. Father's Name					18. Mother's N		, Maiden Sumami	e)	
lar	0 5 0 0	108	Raymond	C. Burk	hart			Nellie	(Bir	ch)		
Maryland	d 2 sh th end 7 is m traum		19a. Informant's Na James A.	me/Relationship (Type, Print)	Rt.	b. Meiling Address (Street and Number or 140; Ridge	Rurel Route Number	ber, City or Town, 3	State, Zip C	Code)
re,	it of Heal if ham 2 or other		Tusband 20a, Method of Disp			comet	of Disposition (Name	of	Date	20c. Location -	City or Tow	m, Slate
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alti	permit. Pege Department of Important: If any injury or ance.		21. Signature of Fu	neral Service Lice	nsee	۸۸	Scarbe	rarass of affice	ral Home	P.A.	PIINA.	, , , , , ,
m	Depa Impo		Mich	L. rala	MAN	nollt	Cumber:	land, MD	21502	,		
			23e. Pert1. Enter the	ne diseese, or com	plications that caus	ed the death. Do	not enter the mode	of dying, such as card	liac or respiratory	arrest,		Approximate Interval Between
	Physician		SHOOK, OF HOL	Trondie. List Gray	One cause on each	anno.						Onset and Death
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88	Examiner		resulting In death)		a. J. H. Labella		consequence of):	Start			1	
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68760,	ficete be axecul physician and as the burial-tran		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of): CREPAIR abdominal aortic aneurysm Due to (or as a consequence of):								2.	5 months
387	phys s the	olo	resulting in death) Last									
	centif ding	Be Completed by Physician/Me			d. Left ne	phrector	my for rer	nal cell ca	/. /	A find	2.	5 months
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P.O.	that the c		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco ues contribute to the cs 1 ☐ Yes 2 ☒ No 3 ☐ Probably			ably 4 □ Unknown
	s that		Perforate	d sigmoi	d colon				_	7,100 2,72,110		
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of V	Physician: this certific rel director,	10		No released	Hospital:	atient 2 ER/C	Outpatient 3 DO	Other: 4 Nursin	g Home 5 ☐ Res	sidenca 6 🗆 Othe	er (Specify))
n c			27. Manner of Death	n 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Year) 28b		c. Injury at Work?	28d. Describe	how injury occurr	be	
sio	Attending ir death. actor: After by the lune	cati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b	NO.		М	1 ☐ Yes 2 ☐ No	00/ 1	(0)		0-1-1-1-1
Division	7 7 7 6	Certification:	4 ☐ Homicide	determined	286. Placa of	Injury - At home, etc. (Specify)	farm, street, factory,	offica		(Street and Number own, State)	er or Hurai	House Number,
	phal phal		200 Codilina	M. Carriedon Di		at ad any transition of	and a death account of all	t the time data and d	and due to the	a acusa(a) and ma		atod
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: complately filled in by the	Medicai	29e. Certifier (Check only one)	2 ☐ Medical Exam	niner: On the basis and manner	of examination a	nd/or investigation, i	the time, date end plan n my opinion, death o	ccurred at the time	, date end place, e	and due to	the cause(s)
	o the	Me	29b. Signature and	title of certifier	1	,	29c.	License number		29d. Date signed	1 (Month, D	lay, Year)
	5	'	10 K	1/1/2	telines	y w	J D1	7456		T1. 00		2000
			30. Name and addr	esa of person who	completed cause o	death (Item 23a		7430		July 23	5,	2000
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DHMH 16 Rev 6/95

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Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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		1. Decedent's Nama (First, Middle, La	est)		Maria de la		2. Dete of Dea			. Time of Death	
	Physician	Ralph Dominic	Phillip	Winn	er		Month July 23	Dey 2000	Yaar	:00A.M.	
	/Medical	4a Facility Name (If not institution, gir				4b. City, Town, or I		4c. County		:00A.M.	
	Examiner	4a Facility Name (II not institution, gr	ve street and number)								
		Memorial Hospita	1 & Medica	l Center			Cumberland		gany		
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		Usual Rasidence of Decedant									
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la y	or or	MD Allegany LaVale								Yas 2□No	
9	8 5	10e. Street and Number 10f. Zip Coda 10g. Cit								21	
7	or 2	10e. Street and Number				0g. Citizan of What Country?					
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21215-0020 d within 72 hours af	by F		If Yas, Giva Yaar or Datas:		1□ Yes 2√2 N	Yes 2 No Specify:			SpecWhite		
S S	P P	15. Decedent's E	1	16a Doo	edent's Usual Occ	unation		16b. Kind of B	usiness/Indust	to.	
d 21215-0020 filed within 72 hours after death with the Manyland	vgiene. ner than "natural", r, me Medical Exe Completed by	(Specify only highest gr		(Giv	a kind of work don	a during most of wor	rking	100. Kind Qi B	usiriass/iridusi	,	
7 E	than than	12 Elementary/Secondery (0-12)	College (1-4or 5	Pipef	DO NOT use reti	rea)	P	&O Rai	lroad		
N S	Hygiane. om, m. e Comp	12		Liber	TCCET						
D =	of other avent, passent, passe	17. Father's Neme (First, Middle, Las					ma (First, Middla,		ne)		
Maryland d2 should be file	Menta irked itic e	James Clifton	Winner			Raphae]	LA (P	arker)			
arylan should be	h and Mental 7 is marked of traumatic av	19a. Informant's Name/Ralationship	(Type, Print)	19b. Mei	ling Address (Stre	at and Number or Ru	ural Routa Numbe	r. City or Town,	Stete, Zip Co	ide)	
M 2		\$haron Winner	(.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11 H	olly Av	renue; La	Jale, M	D21502			
C	Hem 27 i	20e. Mathod of Disposition		20b. Place of Disp	position /hlama of		2-1-	00-1	Oib T	Charles	
	10 T	20e. Mathod of Disposition	Removel from State	cematery, cri	ematory or other p	olaca)	Data	20c. Location	- City or Town,	, Stata	
E Pag	ant: If its	4 Donation 5 Other (Speci		Porter C	emetery	r	7/25/ \$	tringt	own.	PA	
= =	# E E A	21. Signature of Funaral Sarvice Lice				ris Fallera					
B S	Dep muy puc	1111	1 hon.								
		Cumberland, Maryland 21502									
		23a. Part1. Entar tha disease, or con	notications that coused	the death. Do not e	nter the mode of d	lying, such es cardiac	or raspiratory err	est,	Ap	proximata tervel Between	
Ph	nysician	Onsat and Death									
	/Medical										
E:	kaminer	disease of condition resulting in death) a. Chronic Renal Failure, requiring dialysis 15 years									
		Due to (or as a consequence of):									
g	in sit	Sequentially list conditions, Cerebrovascular Accident Dua to (or as a consequence of):								ays	
cute	in end fal-trensit Examiner										
O S	E Tarie	if eny, leeding to immadiata ceuse. Entar Undarlying	Atherosc	lerotic Va	ascular I)isease			15	years	
ox 68760, cartificate be executed	nding physician end usa as the burial-trensit in/Medical Examir	Sequentially list conditions, if enry, leeding to immadiate ceuse. Entar Undarlying Cause (Disease or injury thet initiated events Dua to (or as a consequence of): Atherosclerotic Vascular Disease Dua to (or as a consequence of):								,	
68760, tificate be ex	A the state of the	rasulting in death) Last		Dag to (0, as a 00,100	oqualiou oiy.						
OX	ding sa a		d								
Bo ta	or u								1		
. 6	hed by the etta dateched for y Physicia	Pert II. Other significant conditions	contributing to death be	ut not rasulting in the	underlying cause	given in Pert I.	23b. Did to	obacco uae co	ontributs to th	e cause of death?	
P. of the	tech thy						101	es 2 No	3 Probab	y 4 Unknow	
S, Es tha	be da	Emphysema, Conges	tive Heart	Failure			100				
Ords							24a. Was a	an autopsy	24b. Wera	autopsy findings	
0 6	cate hes been single 2 should Completed	Aortic Abdominal	Aneurysm,	Dementia			perfor			bla prior to lation of cause	
e ec	hes b								of dea	ith?	
T a	ate he page						1 D Y	es 20 No	1 🗆 Y	as 2 No	
<u>a</u>	cartificate rector, pa	25. Wes case rafarred to medical	1			26 Place of De	ath (Check only or	nel	1		
of Vital Record	s cartifica director, I	axaminar?	Hospital:	· • • • • • • • • • • • • • • • • • • •		Wher:			10		
Phys	this aldi	1 Yas 2 No	1 Unpatia		ent 3L DOA	4 LI Nursing P	loma 5 ☐ Resid				
C 8	After funal	Naturel 5 Pending	28e. Deta of Injur (Month, Day	ry Year) 28b. Tima Injury		ijury at Vork?	200. Dascribe in	Ow injury occu-	1100		
Division or Attending		2 Accident invastigetic			M 1	□ Yas 2 □ No					
A V	Director: Lin by tha ertifica	3 Suicide 6 Could not to determined	28a. Plece of Inju- building, etc	ury - At home, farm, s	straat, factory, offic	> 9	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			outa Number,	
0 0	din by		bonong, etc	z. (Opecny)			0.0, 0.10	,,, 0,14,14,			
Hospital	fille fille	29a. Certifier Certifying P	hysician: To the best of	of my knowledge, des	ath occurred at tha	tima, data and place	a, and dua to the c	ause(s) and m	ennar es state	ed.	
	in 24 hou he Funer plataly fil edical	(Check only 2 Medical Exa	miner: On the basis of	axamination and/or i	invastigation, in m	y opinion, daath occu	rred et the time, o	date and place,	and dua to the	a cause(s)	
\$	within 24 hours effer To the Funerel Dire complately filled in b Medical Certi	one)	and mannar sta	100.	00-11	and an about		Od Data size	ad Alasta Da	v Vood	
1º	To CO	29b. Signeture and title of certifier	0	(ense number		29d. Data signa	au (Month, Da)	y, rear)	
	10	Denlo	regol	De	D54	411	7	ر ۱۱۰۰	2	2000	
	10	30. Name and addrass of person who	completed cause of d	eath (Item 23s) (Tyro	Print)		J	uly <	,)	2000	
	4/1	Beverly M. / Ca	lkins M.	D. 500 M	emorial	Ave Ste	105 C	umberl	and M	D21502	
	The	- 0			-						
	State	31. Data filed (Honths) Pag. 191100	2. Registra	ar's Signeture	Son d	1					

Registrar

many to some the same

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth AMoghat 3Day 2000 Year **Physician** 2:40am Gertrude Anna Appleby /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore 4a Facility Name.(If not institution, give street end number) Examiner Middle River If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplece (Stete or Foraign Country) **Funeral** Deys Hours 1 □ M 2 🗗 F 220-43-5139 96 Yrs 1904 Director May 13, Maryland Usual Rasidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No MD Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 Usa 10 Taxis Way Funeral death 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 13. Was Decedant of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Nevar Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast greda complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home than Elementery/Secondery (0-12) College (1-4or 5+) Homemaker other 1 18. Mother's Nema (First, Middle, Maiden Sumeme) 17. Fether's Nema (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other treumatic event and the state of the present of the state o Elizabeth Scharnagel Patrick Denny Casey 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Harry E. Appleby 1522 Doxbury Rd., Towson, MD 21286 20b. Plece of Disposition (Neme of cometery, cremetory or other plece)
Loudon Park Cemetery 20e. Method of Disposition Date 20c. Location - City or Town, Stete Aug 2000 5 1 Buriel 2 Cremetion 3 Removel from Stete Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Facility
Evans Funeral Chapel 8800 Harford Rd. Parkville, MD 23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, book, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Our Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, If any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Dua to (or es a consequence of) attending physician for use es the buna P.O. Box 68760. Due to (or es a consequence of) 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 D Onknown been signed by Division of Vitai Records, þ 8 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed i certificata has l 1 Yes 2 Tho 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 PAesidenca 8 Other (Specify) 1 Yes 2 No 10 this 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending ours after death. eral Director: Aft filled in by the fur 1 Yes 2 No investigetion 2 Accident 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D complately filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) end manner stated. edicai 29e. Certifian 29d. Date signed (Month, Day, Year) 29b. Signature and tight of certifier 29c. License numbe 00 30. Name and address of person who complated cause of death (item 23a) W 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State AUG 0

DHMH 16 Rev 6/95

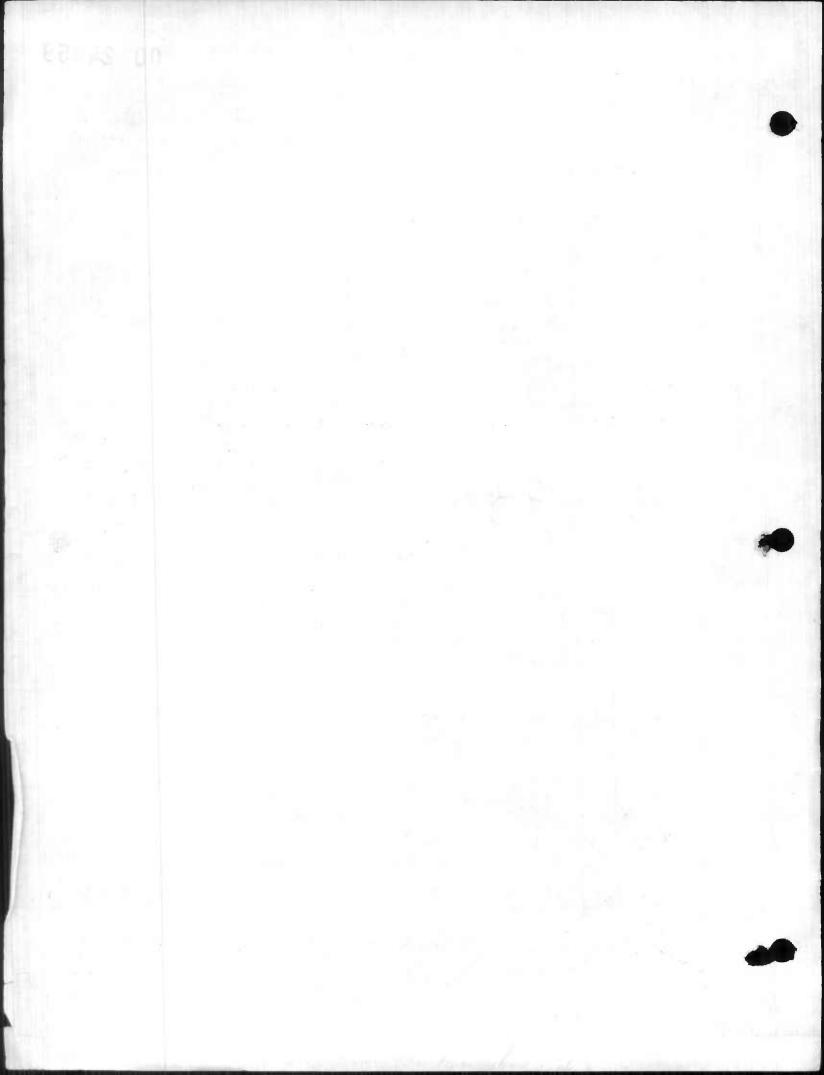
Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 24859

			C	ertificate	e of l	Death		Reg. No.	0 4	700	
	1. Decedent's Name (First, Middle, L.	ast)					2. Date of De Month	ath Day	Year	3. Tima of E	leath
Physician /Medical	Jessie S. Adams						August		2000	2:00	a.r
Examiner	4a Facility Name (If not institution, gr	ve street and number)			4	b. City, Town, or L	ocation of Death	4c. Count	y of Death		
	Genesis Elderca	re-Severna Pa	ark		5	Severna F	ark	Anne	Arur	nde1	
Funeral	5. Social Security Number 6.	Sex 7. Age (h	yrs. last birthde	y) If Under		If Under 24 Hrs.	8. Date of Birt (Month, Da	h	9. Birthp	place (State or	Forei
Director	248-03-0962	1□M 21 F	97 Yrs.	Months	Days	Hours Min.	May 15		Texa		
_	Usual Residence of Decedent		1-2-				,		1 20110		
Mon W	10a. State 10b. County	10	c. City, Town or	Location					1	Od. Inside City	Limi
hied with 22 hours are cean with the maryand ther than 'natural', or items 23a or 28a-f ahow out, the Medical Examinar must be notified at a Completed by Funeral Director	MD Anne A	rundel	Severna	Park						1 ☐ Yes	2 (X) P
or 28a-fall be notified Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Cour	ntry?	
23a or 28a-f ahow mat be notified at	24 Truckhouse Road 21146 USA										
r tems 23s instrument Funeral	11. Marital Status	12. Was Decedent Eve	r in U,S. 1				ecify Yes or No		ce - Americ		
Få D	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2♥ No		S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto					sck, White,		
natural, or	3XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	XXVO	Specify:		Speci	y: Wh	ite	
2 B	15. Decedent's E		16a. De	cedent's Usua	Occup	ation		16b. Kind of E	Business/Inc	dustry	
ygiene. ner than "naturn rt, tre Medical Completed	(Specify only highest go	rade completed) College (1-4or 5+)	(Gi	ve kind of wor b. DO NOT us	k done d e retired	during most of world	king				
Hygiene. ont, tre the e Comp	6	College (1401 34)	S	pinner				Text	ile		
d other event,	17. Felher's Name (First, Middle, Las	t)				18. Mother's Nam	e (First, Middle,	Maiden Suma	me)		
Mental erked o etic eve	James Jackson Sm	nith				Matild	a Shirle	ey Smith	2		
and Men a marke aumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address	(Street	and Number or Ru				Code)	
47.4	Rebecca Grigg (D		124	Boyd	Driv	e, Annap	olis. MI	21403			
115	20a. Method of Disposition		20b. Place of Dis	position (Nan	ne of		Date	20c. Location	- City or To	own, Stete	
	1 X Burial 2 Cremation 3			rematory or of			2000	G1			
The Land	4 Donation 5 Other (Special Signature of Funeral Service Lice		Woodsid	22. Name and	- 100		2000	Clove	r, so	uth Car	0.
Department of Important: If any Injury or pace.	21. Signature of Funeral Service Lick	041.		Harde	sty	Funeral	Home, P	.A.			
	Mechele	y Juli	0			ly Avenue			ID 214	101	
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	noncations that caused the y one cause on each line.	death. Do not	enter the mode	of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw	reen
hysician									-	Onset and De	ath
Medical	Immediate Cause (Final disease or condition	7	emonia					1	dan	V	
xaminer	resulting in death)	Due to (or as a consequence of):							1		
4 E			us,	o ho	9	1a				mon	X
n and selfransit Examine	Sequentially list conditions,	Due Due	to (or as a cons	sequence of):	Ó			-			
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ing physician as the burs Medical E	Cause (Disease or injury that initiated events Due to (or as a consequence of):										
Med Med	resulting in death) Last								1		
e attendin of for use siclan/	TOTAL TOTAL	d									
of for	Part II. Other aignificant conditions	contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the ca		o the cause of	l de			
d by the attend letached for us Physician/	1.0	2+1	and in the uncertainty cause given in Fait i.				1 Yea 2 No 3 Probably				
ped y	blindne	ess a	eager	-	>			1			
page 2 should be d			0				24a. Was	an autopsy	24b. W	ere autopsy fir	nding
sho sho							perfo	rmed?	00	railable prior to empletion of ca death?	use
1 8 P							45	100			NI -
Co Co	06 What are 1						10		11	Yes 201	40
nector Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea					
To Ti	1 ☐ Yes 2 No 27. Manner of Death	1 L Inpatient	2 ER/Outpa		Bc. Injur	Nursing H	ome 5 ☐ Resi			(y)	
After	1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time Injur		Wor	k? Yes 2 □ No	200. 0000100	now injury occi	260		
for: the	Accident investigation	he -	44.5-			149 ∠□140	20f Leasting (Street and Mr.	shor or D.	al Davida Mirant	205
a aher death. al Director: Aher ted in by the funent ed in by the funent Certification:	4 Homicide determined		At nome, lam, Specify)	street, factory	, Office		28f. Location (City or To		IDEI OF HUN	EI NUUTO NUME	·01,
n 24 hou ne Funer pletsky fil edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of exa									
	one)	and manner stated									
To To M	29b. Signature and title of certifier	116	1	290	Licens	e number		29d. Date sign	-		
6	in	0	-		D	14145	5	8-	2-1	00	
der	30 Name and address of person who	completed cause of death	(Item 23a) (Tyr	Print)			11 -	016	CIM	rnst	2
ms.	Kelseccal).	+ krM	7 47	9 1	er	- De	Holo	69	L	021	12
State	11. Date liled (Month, Day, Year)	32. Registrar's	Signature	()1	1,,	1	1		1-1	1	4
Registrar	AUG 0 8 21	100 Sever	me to	00	ack	3					

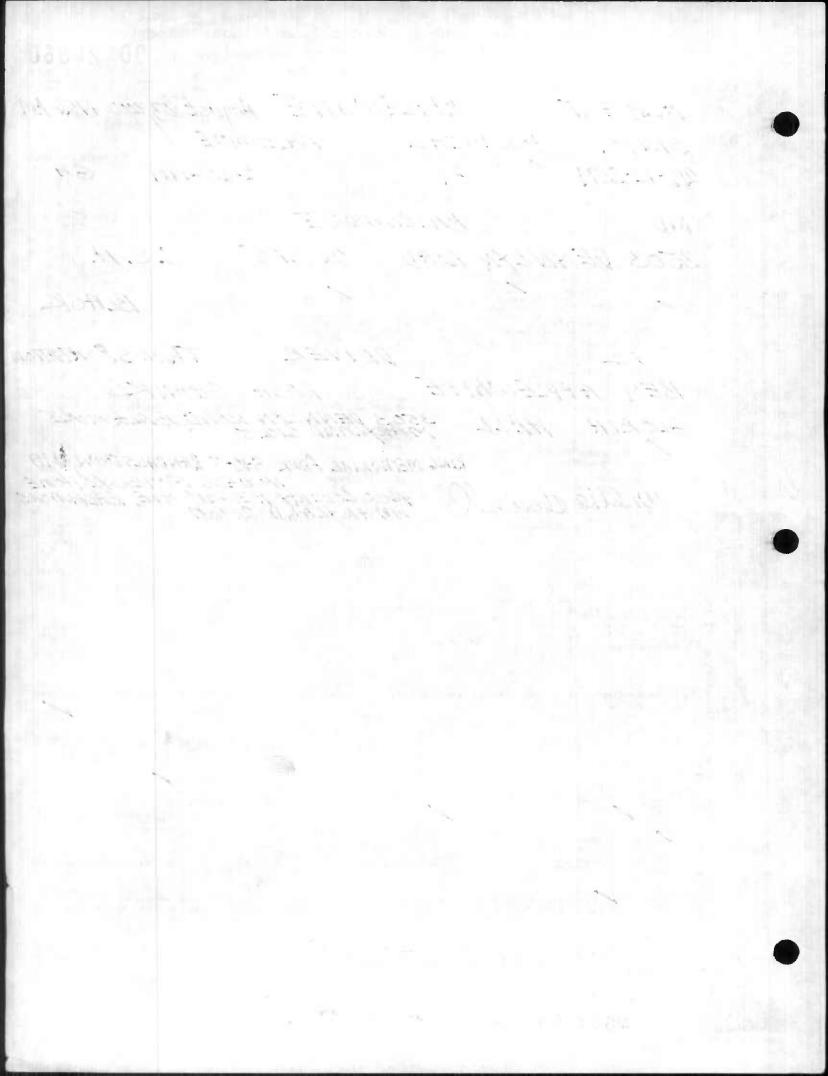
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State of Maryland / Department of Health and Mental Hygiene

		Certifica	te of Death	Reg. No.		
Dhusisian	Decedent'a Name (First, Middle, Last)	DODIE.		2. Dete of Deeth	3. Time of Death	
Physician /Medical	ALBERT	APPLEU	INITE	voust 03,	2000 1/26 AM	
aminer	4e Fecility Neme (II not institution, give street end num	nber)	4b. City, Town, or Local	tion of Death 4c. County	of Deeth	
	SINA / Has	PITAL	BALTI	MORE /		
	5. Social Security Number 6. Sex	. Age (In yrs. lest birthdey) If Under Months	or 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)	
	216-12-5379 120F	8/ Yrs.	Days Hours Will.	1-20-1919	GA	
	Usual Residence of Decedent					
	10a. Stete 10b. County	10c. City, Town or Location			10d. Inside City Limits	
DIRECTOR	MA	BALEIM	IORE		1 ≥ Yes 2 □ No	
	10e. Street and Number	10f. Z	ip Code	10g. Citizen of W	/hat Country?	
	ZEMZ DENNILY	M DOAD	11015	111	SA	
+	11. Meritel Stetus 12. Wes Dece	dent Ever in U,S. 13. Wes Deci	edent of Hispanic Origin? (Spec	ifv Yes or No-	- American Indien,	
١	1 Never Merried 2 Merried 1 res	ces? If Yes, sp	edent of Hispanic Origin? (Specedify Cuban, Mexican, Puerto Ri	can, etc.) Blac	k, White, etc.	
	3 ■ Widowed 4 □ Divorced Yeer or De	e 1 ☐ Yes	2 No Specify:	Specify	BIACK	
-		16a. Decedent's Us	ual Occupation	16b. Kind of Bu	siness/Industry	
	15. Decedent's Education (Specify only highest grade completed)	(Give kind of w	ork done during most of working use retired)	7 OD. KING OF DE	an lood in Cubiny	
Completed	Elementary/Secondary (0-12) College (1	-40f 5+)	IVER	TOAL	IC PARTIATION	
	17. Father's Neme (First, Middle, Last)	UK		First, Middle, Maiden Surnem	al Childi	
9	D 1 191511	16,45	naca	- ILM ALL	-	
9		shite	1000H	SITHNI	<u> </u>	
	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Addres	ss (Street end Number or Rural)	Route Number, City or Town,	Stete, Zip Code)	
	GLORIA HAL	L mary	CAND SIDI	EUND, JOH	ZETMOC	
	20a. Method of Disposition	20b. Plece of Disposition (Na cemetery, cremetory or	other plece)	Dete 20c. Location -	City or Town, Stete	
	1 Buriat 2 □ Cremetion 3 □ Removal from 5 4 □ Donetion 5 □ Other (Specify)	KING MEMAN	OWN DOON 8-	M-M PANDAL	LSTOWN, MD	
	21. Signeture of Funeral Service Licensee	22. Neme o	and Address of Fecility	IETI GUAL	EDIN/ HOME	
	111,00in H .	1 4600	11 hFhH H	SELL FUNC	ENLINKE?	
_	wixing Cow	I im	4 49 1// 61 3 // 1	217117		
	23e. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each	aused the deeth. Do not enter the modern terms.	or or ing, such as our diac or	respiratory errest,	Approximete Intervel Between	
					Onset end Death	
	Immediate Cause (Finel disease or condition MY(CARDIAL INFAR	CTION			
	resulting in death)	Due to (or es e consequence of				
CAGIIIIII	Sequentially list conditions, if eny, leading to immediate	Due to (or es a consequenca of):			
ľ	if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events					
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Medical	resulting in death) Last				1	
	d					
	Part II Other elanificant conditions contribution to de	ath but not reculting in the undertains	cause gives in Dest I	23h Did tohacoo uca con	ntribute to the cause of death?	
	Pert II. Other significant conditions contributing to de	ath but not resulting in the underlying	vause given in reit!.			
				1 Yee 2 No	3 Probably 4 Onknown	
					24h Ware sutoney lindings	
				24a. Wes an autopsy performed?	24b. Were autopsy tindings eveilable prior to completion of cause	
Completed					of death?	
				1 Yes 2 No	1 ☐ Yes 2 ☐ No	
9	25. Was case referred to medical	Cal 25 VID. 10 - 10 C. 1	26. Plece of Deeth	(Check only one)		
	examiner? Hospitel:	npatient 2 ER/Outpetient 3 0	Other	e 5 Residenca 6 Oth	ar (Spaciful	
10	27. Menner of Death 28a. Detect			3d. Describe how injury occur		
5	1 Netural 5 Pending (Month	h, Dey Year) Injury M	28c. Injury et Work?	200. Describe now injury occurred		
Certification:	2 Accident investigation 3 Suicide 6 Could not be			of I postion /Street and Numb	or or Burni Bouta Alumbar	
Ē	determined 200. Flece	of Injury - At home, ferm, street, lectong, etc. <i>(Specify)</i>	iry, offica	Bf. Location (Street end Numb City or Town, Stete)	er or nurar noute rumber,	
		best of my knowledge, deeth occurre sis of examinetion and/or investigation				
	end menn		th, army opinion, death occurred	, or the time, date end place,	one due to the conse(s)	
2	29b. Signature and title of certifier	1 1 2	9c. License number	29d. Date signer	d (Month, Dey, Year)	
	Malashe H	Se Ind,	205504	1 HIA	NT 8 2000)	
	20 Name and address of assets	of death (New 202) (To a 201)	100001	7.0.00	0,200	
	30. Name and eddress of person who completed cause					
,	NATASHA A. STINSON	3091 THE ALAM	EDA BALTIMO	RE, MD 212	1.8	
е		egistrar's Signeture	oaks			
istrar	ANCAS 2000	1 / L				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 29 per verbal response G786 8/8/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** cone 1010 AP en 9 -110 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** Nursins OWAVA OVICE Oly 8 Colum Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex -7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Days Hours Yrs. Director 220-03-5389 Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Nems 23s or 28s-f short net must be notified at Yes 2 No Director Maryland n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1306 Division Street 21217 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vant of Haalth and Mental Hygiena. Int: If Item 27 is marked other then "natural", or Items 23. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Timed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: by Specify 3 XWidowed 4 ☐ Divorced Black Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Community Organizer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Gilbert Jones Sadie Dent 19a. Informant's Name/Relationship (Type, Print) grand 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Haaith a Toni Douglas 2112 Brink Court Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Dapartmant of Important: If any injury or once. = 6 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran Cem/Garrison Owings Mills, Maryland Aug 11 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 and Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, hock or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Finel Cancer disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner The law requires that the death certificate be axecuted the burial-trans Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) 88 USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 9 24b. Were eutopsy findings evelleble prior to Completed 24a. Was an autopsy completion of ceuse of death? page 2 cartificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director. Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Shis 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation 1 Naturel s after death. 1 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

P.O. Box 68760. Records, Division of Vital To the Hospital of within 24 hours at To the Funeral D completely filled it

21215-0020

Baltimore, Maryland

State Registrar DHMH 16 Rev 6/95

Medical

29a. Certifier

KAZIOW 31. Date-filed (Month, Day, Year) AUG 0 8 2000

29b. Signeture and title of certifier

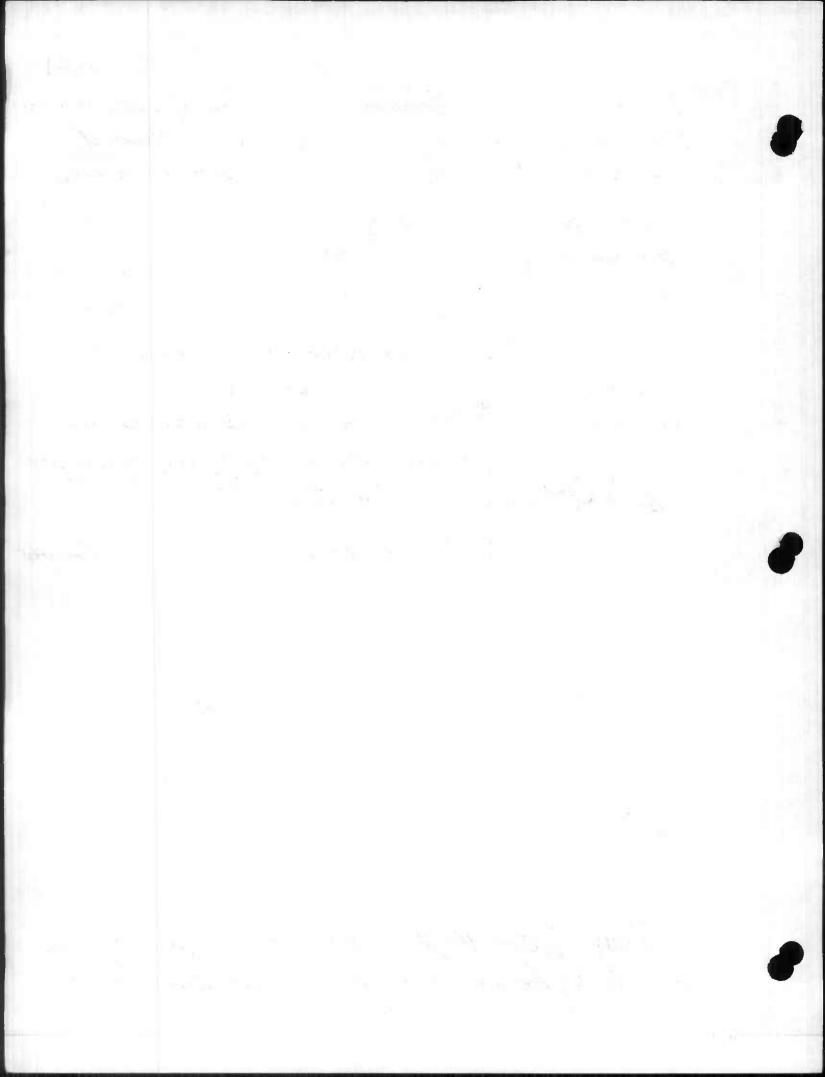
ed cause of death (Item 23a) (Type, Print)

Hickory Ridge Red Columbia Med 2104

15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner steted.

29c. License number

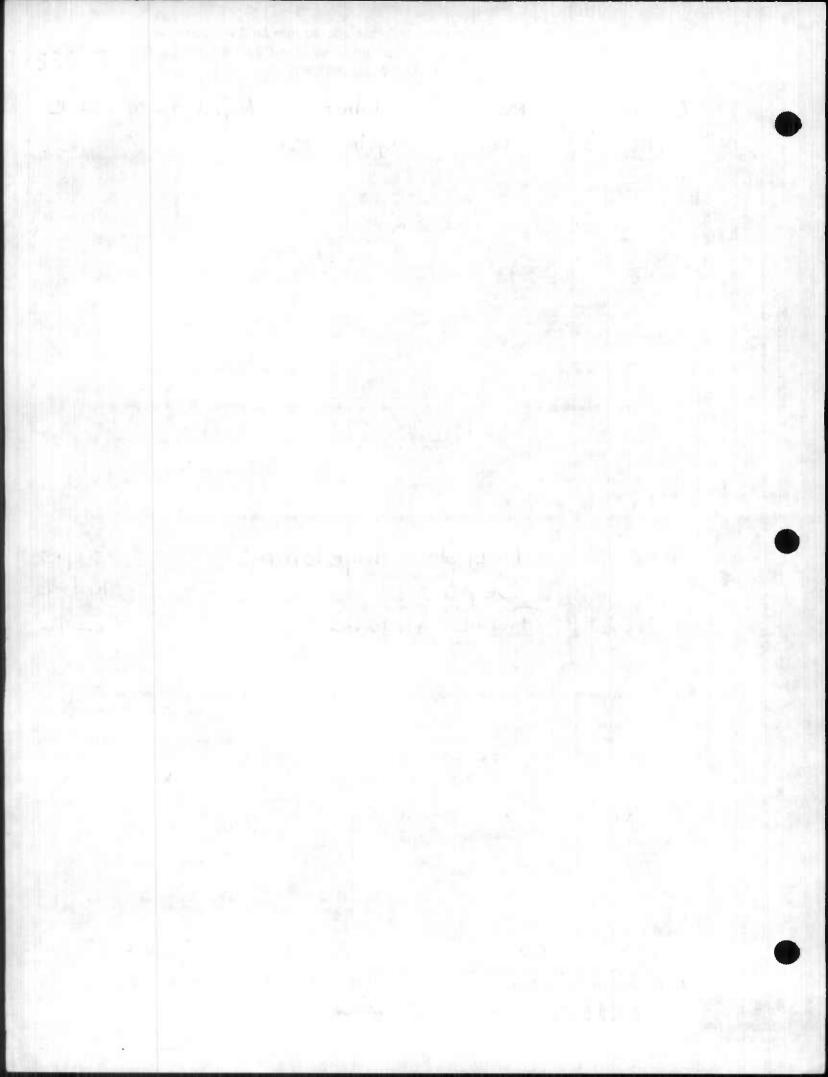
29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 00

24862

			Certifica	ite of Death		Reg. No.	0 24		
- uninion I	1. Decedent's Name (First, Middle, Last)		0	1	2. Date of De	eath 1 Day	Veer	me of Death	
hysician /Medical	ESSIE	M.	12	DIAIR	Augus		00 15	:15_	
xaminer	4e Facility Neme (If not Institution, give :	street and number)	- 11 '	4b. City, Town, o	Location of Deat		of Death NA		
	The John		15 Hospi	ler 1 Yeer If Under 24 Hr	(t, mor	9		Made as Fassia	
ral tor	237-06-6139	7. Age (in yrs	S. last birthdey) IffUnd Month		. (Month, De	3-51	9. Birthplace (S Country)	SC SC	
134	Usual Residence of Decedent 10a. Stete 10b. County	10c. C	City, Town or Location				10d. Ins	ide City Limits	
50								Yes 2 No	
Director	MD NA 10e, Street and Number	В	altimore	Zip Code		10g. Citizen of V	Vhat Country?		
0	1823 N. Chapel	Street		21213		USA			
hera		12. Wes Decedent Ever in	U,S. 13. Wes Dec	edent of Hispanic Origin? (becify Cuban, Mexican, Pue	Specify Yes or No		e - American Indi	en,	
by Fur	1 Never Married 3 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:		2 ¹⁵ No Specify:	nto Hican, etc.)	Specify	k, White, etc. Black	ς.	
pet	15. Decedent's Edu	cation	16a. Decedent's Us	sual Occupation	. 41	16b. Kind of Bu	siness/Industry		
Completed	(Specify only highest grede Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	sual Occupation work done during most of w 'use retired)	orking				
200	7th Grade	NA	Presse			Nation		ndry C	
Be	17. Fether's Name (First, Middle, Last)	- ·			ame (First, Middle				
To		Simon		Anni		Charle			
	19a. Informant's Name/Relationship (Ty	nber, City or Town, Stete, Zip Code) 2121.							
	James Blair	20h	1823 N. Place of Disposition (A	Chapel St	reet Ba	-	e, Mary City or Town, Ste		
	20e. Method of Disposition X ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State							
	4 Donation 5 Other (Specify)			em. Gardes	1		Dundalk		
	21. Signature of Funeral Service License	and o		and Address of Facility . March FH	Baltimo 1101 E.		-		
	23a. Part / Enter the disease, or compli shock, or heert failure. List only or	ications that caused the de-					Appro	ximete al Between	
				1			Onset	and Death	
	Immediate Cause (Final disease or condition	Multip	ole M	rue lome	7		3	415	
-	resulting in death) Due to (or as a consequence of):								
nlne		Deps	SIS	Callin A. C.			100	or Hys	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury c.								
	Cause (Disease or Injury that initiated events	TrenAL	THILL	10			121	WIG	
edical		Due to	(or as a consequence o	1):					
	resulting in death) Last								
		d							
	resulting in death) Last		sulting in the underlying	cause given in Pert I	23h Did	tobacco usa co	ntribute to the c	euss of death	
	resulting in death) Last		esulting in the underlying	g cause given in Pert I.		tobacco use co		auss of death	
Physician/M	resulting in death) Last		esulting in the underlying	g cause given in Pert I.				V	
Physician/M	resulting in death) Last		esulting in the underlying	g cause given in Pert I.	1 = 24a. Wa	Yes 2□ No	3 Probably 24b. Were aut available	4 Unknow	
Physician/M	resulting in death) Last		esulting in the underlying	g cause given in Pert I.	1 = 24a. Wa	Yes 2□ No	3 Probably 24b. Were aut available	opsy findings prior to on of cause	
Physician/M	resulting in death) Last		esulting in the underlying	g cause given in Pert I.	1 = 24a. War	Yes 2□ No	3 Probably 24b. Were aut available completic	opsy findings prior to on of cause	
e Completed by Physician/M	Part II. Other eignificant conditions con		esulting in the underlying		1 = 24a. War	Yes 2 No	24b. Were aut available completic of death?	opsy findings prior to on of cause	
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edical Certification: To Be Completed by Physician/M	Part II. Other eignificant conditions condit	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Dey Year) 28e. Placa of Injury - At building, etc. (Special Control of the best of my kr	□ ER/Outpatient 3□ 28b. Time of Injury M home, farm, street, fact involvedge, deeth occurretion and/or investigation.	26. Place of D DOA Other: 4 \(\text{Nursing} \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) ory, office and at the time, dete end ple on, in my opinion, death oc	24a. Wa: perl 24a. Wa: perl 1 □ eeth (Check only) Home 5 □ Res 28d. Describe 28f. Location City or To	Yes 2 No s en autopsy ormed? Yes 2 No one) idenca 6 Oth how Injury occur (Street and Numb own, Stete) c cause(s) end me date end pleca,	3 Probably 24b. Were aut available completic of death? 1 Yes er (Specify) red per or Rurel Route anner as stated, and due to the ca	opsy findings prior to on of cause 22 No	
Certification: To Be Completed by Physician/M	Part II. Other eignificant conditions con 25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Naturel 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) 1 Certifying Physical Examination Condition Co	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Dey Year) 28e. Placa of Injury - At building, etc. (Specials Control of the basis of examinand manner steted.	□ ER/Outpatient 3□ 28b. Time of Injury M home, farm, street, fact involvedge, deeth occurretion and/or investigation.	26. Place of D DOA Other: 4 \(\) Nursing 28c. Injury at Work? 1 \(\) Yes 2 \(\) No ory, office and at the time, dete end ple on, in my opinion, death oc 29c. License number	24a. Wa: perl 24a. Wa: perl 1 □ eeth (Check only) Home 5 □ Res 28d. Describe 28f. Location City or To	Yes 2 No s en autopsy ormed? Yes 2 No one) idenca 6 Oth how Injury occur (Street and Numbown, Stete) c cause(s) end ma, date end pleca,	3 Probably 24b. Were aut available completic of death? 1 Yes er (Specify) red er or Rurel Route anner as stated, and due to the condition of the condition	4 Unknow opsy findings prior to on of cause 2 No e Number, ause(s)	
edical Certification: To Be Completed by Physician/M	Part II. Other eignificant conditions condit	Hospital: 1 Impatient 2 28a. Date of Injury (Month, Dey Year) 28a. Placa of Injury - At building, etc. (Special Clan: To the best of my kner: On the basis of examinand manner steted.	BER/Outpatient 3 28b. Time of Injury M home, farm, street, fact nowledge, deeth occurretion and/or investigati	26. Place of D DOA Other: 4 \(\text{Nursing} \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) ory, office and at the time, dete end ple on, in my opinion, death oc	24a. Wa: perl 24a. Wa: perl 1 □ eeth (Check only) Home 5 □ Res 28d. Describe 28f. Location City or To	Yes 2 No s en autopsy ormed? Yes 2 No one) idenca 6 Oth how Injury occur (Street and Numb own, Stete) c cause(s) end me date end pleca,	3 Probably 24b. Were aut available completic of death? 1 Yes er (Specify) red er or Rurel Route anner as stated, and due to the condition of the condition	opsy findings prior to on of cause 22 No	
edical Certification: To Be Completed by Physician/M	Part II. Other eignificant conditions condit	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Dey Year) 28a. Placa of Injury - At building, etc. (Special Control of the basis of examinand manner stated.	DER/Outpatient 3D 28b. Time of Injury M home, farm, street, fact iffy) nowledge, deeth occurretion and/or investigation and/or investigation.	26. Place of D DOA Other: 4 \(\) Nursing 28c. Injury at Work? 1 \(\) Yes 2 \(\) No ory, office and at the time, dete end ple on, in my opinion, death oc 29c. License number	24a. Warperl 24a. Warperl 1 □ eeth (Check only) Home 5 □ Res 28d. Describe 28f. Location City or To	Yes 2 No s en autopsy ormed? Yes 2 No one) idenca 6 Oth how Injury occur (Street and Numb. wm, Stete) c cause(s) end ma, date end pleca, 29d. Date signe	3 Probably 24b. Were aut available completic of death? 1 Yes er (Specify) red per or Rurel Route and due to the call of (Month, Day, Y	opsy findings prior to on of cause 200 No e Number, ause(s)	



State of Maryland / Department of Health and Mental Hygiene

24863 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Bowersox 2000 18=40 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number 4c. County of Deeth Examiner Harford)ay brook Madonna
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) (State or Foreign **Funeral** 83 Yrs. 1 M 2 F Director filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or harns 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11012 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specity: Whisp Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than ondery (0-12) College (1-4or 5+) none 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fill Department of Heelih and Mentel H Important: If Item 27 is marked oth any Injury or other traumatic even page. Pages 1 and 2 should be nent of Health and Mentel 19e. Informant's Neme/Relationship (Type, Print) a Maryland 2/084 20c. Location - City or Town, Stete Madonna 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1) Surial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Concoter Vans Funeral Chapel 21. Signature of Fundirel Service Licensee 22. Name and Address of Fecifity 2325 YORK Rd. TII t enter the mode of drying, such as cardiac or resp anti Enter the disease, or complications that caused the deeth. Do not enter shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical A. S. C. V. D Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner I or Attending Physician: The law requires that the deeth certificate be assecuted after deeth.

Director: After this certificate has been signed by the ettending physician and in by the increat director, page 2 should be datached for use as the burial-transit in by the increat director, page 2 should be datached for use as the burial-transit. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Division of Vital Records. P.O. Box 68760. Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? CVA 1 Yes No 1 Yes 2 10 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Mother (Specify) SON'S home Other: 1 Yes 2 No 3 DOA Medical Certification: To 27. Menner of Death 28d. Describe how injury occurred Injury et Work? 5 Pending investigation 1 Netural
2 Accident 1 Yes 2 No 6 Could not be To the Hospital or Atterwithin 24 hours after der To the Funeral Director completaly filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es stated.

2 Medicat Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DMG 2000 28 31. Dete filed (Month, Day, Year) AUG 0 8 2000 32. Registrer's Signeture Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item#23a perPHYG786 8/16/2000 EW Amended Item#28a,b,d,f perVERBAL G786 8/16/2000 EW Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Dafa of Death 3. Time of Death 910 **Physician** 05 SEYER 00 JAMES /Medical 4c. County of Death
BALTIMORE MEDICAL 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) Examiner CENTER BALTIMORE BAYNIBN JOHNS HOPKINS Hours Min. Feb. 8. Date of Birth Hours Min. Feb. If Under 1 Year 9. Birthplace (State or Foreign MCSS. 7. Age (In yrs. last birthday) Sex 1 M 2□ F **Funeral** Days 262-14-2533 82 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Md Howard Columbia Funeral Director Nerne 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5118 West Penfield Road 21045 USA 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 11. Maritai Status filed within 72 hours after 1 ¥ Yes 2 □ No If Yas, Give 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0020 1□ Yas 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) Constuction Engineering Architect other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental marked L. Vincent Beyer Euphemia Schmidt 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other treu Gilda Beyer 5118 West Penfield Road, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Balt-Wash Crematory 8/8/00 Laurel, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOU 741 Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD Taude Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Physician Immediate Cause (Final diseasa or condition resulting in deeth) /Medical Examiner Due to (or as a consequenca of) Examiner SUBDURAL HEMORRHAGE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events HEAD INJURY P.O. Box 68760, Be Completed by Physician/Medical the 202MA 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 3 Probably 4 Unknown RENAL DISEASE, of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DISEASE, ANEMIA 1 Yas 20 No 1 ☐ Yas 2 No al or Attending Physicien: The state death.

No Director: After this certificated in by the funeral director, post in by the funeral director, post in the funeral director. 25. Was cese referred to medical exempler? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury FOUND: 5:00 P M 28d. Describe how Injury occurred TRIPPED & HIT HEAD ON FLOOR 27. Menner of Death 28c. Injury et Work? Division 2 X Accident 5 Pending 7/10/00 investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 5118 Penfield RD, Columbia, Howard Co, Mi HOME

To the Hospital or within 24 hours after To the Funerel Dire completely filled in b Registrar DHMH 16 Rev 6/95

MRABH

29e. Certifier

who completed cause of daath (Itam 23a) (Type, Print) INHA, BHNS 32. Ragisfrar's Signatura

, MD, PhD-

NEUROLOGY RES.

HOPKINS

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

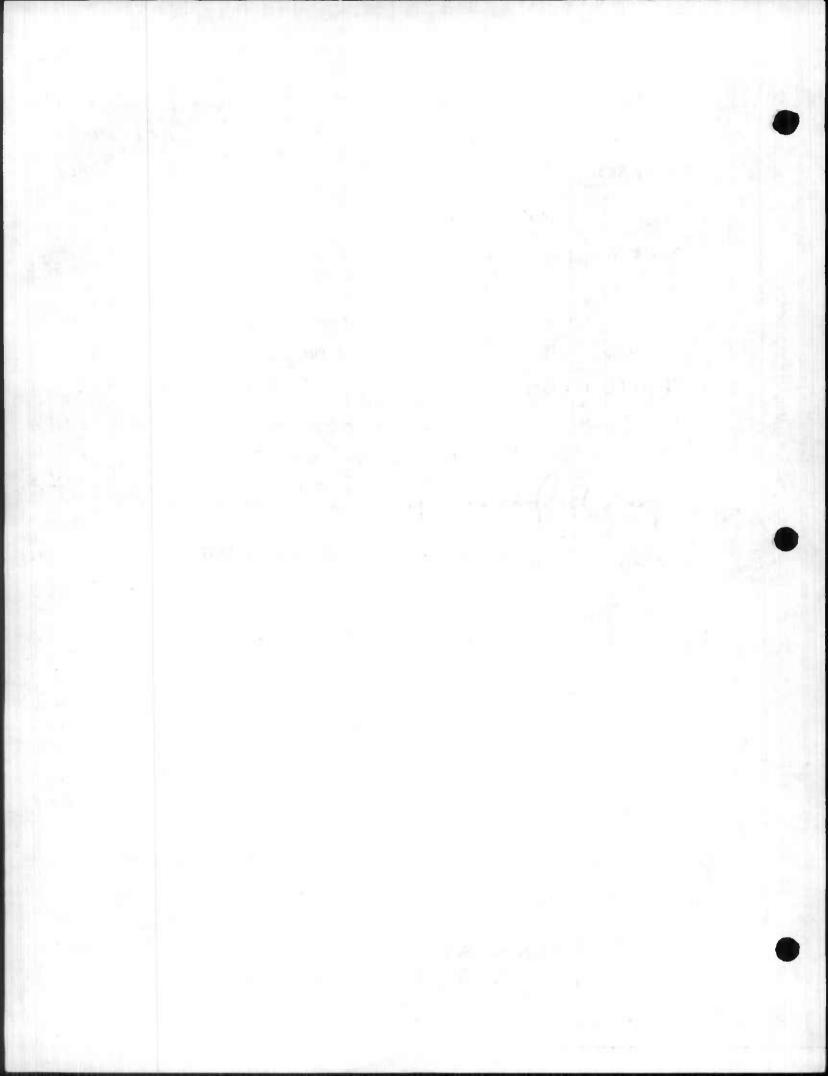
29c. Licensa number

	AMEND	IT	EM: #16A PER F.H.	State of Maryland G78 8-8-00 WR.	d / Departmer Certificat	nt of H	lealth and Death	Mental Hy	giene () Reg. No.	0 2	24865
	Physicia /Medic		1. Decedent's Name (First, Middle, LI CHARLES		BE	ST	1- No.	2. Date of De Month Augus	Day	Year .000	3. Time of Death 0543AM
	Examin	-	4a Facility Name (II not institution, git NORTH WEST	ve street and number) HOSPITAL			16. City, Town, or RANDA				MORE
	Funeral Director		214-86-3580	Sex 7. Age (In yrs. II	est birthday) If Unde Months	Days	If Under 24 Hrs Hours Min.		th y, Year) -1964	9. Birthp Coun	Naca (State or Foreign ntry)
	the Meryland 28a-f show notified at	ctor	Usual Residence of Decedent 10a. Stata 10b. County M. A.				1	0d. Inside City Limits 1 ☑Yas 2 ☐ No			
		Funeral Director	10e. Street and Number 2208 Availa	ca Terrace	10f. Zij		209		10g. Citizen of \	What Coun	. *
	oms 23a or		11. Marital Status	12. Was Decedent Ever in U,S	S. 13. Was Dece		ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		e - Americ	an Indian,
020	21215-002(d within 72 hours egiene. rr than "neturel", o, the Weal Calleron	by	1) Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes		Specify:		Specify		zch
1215-0		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done	during most of wo	rking MPLOYED	16b. Kind of Bo	usiness/Ind	dustry UNIC
Maryland 2		To Be Co	17. Father's Nama (First, Middle, Last	B.S. Degree Best, Jr	541	18. Mother's Nama (First, Middle, Maiden Sumame) Geral Une Herry				18)	
lary	2 should and Mer is marks aumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address		and Number or R	ural Route Numb	er, City or Town,		
Saltimore, N	eges 1 end int of Health t: If Hem 27 y or other tr		20a. Method of Disposition 1) Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from Stata	2208 ace of Disposition (Na imetary, crematory or o	me or other plac	A A	Data 8-9-00	20c. Location- Arbw	City or To	
Baltir	pemit. Pe Departmen Important: any injury		21. Signature of Femeral Service Lice				ss of Facility F, H, W Wabo				***************************************
		1	23a. Part. Enter the disease, or con shock, or heart failure. List only	np Itions that caused the death	Donot entar the mod	de of dyin	g, such as cardia	c or respiratory a	rest,	Pat	Approximata Intarval Between
	Physician /Medical Examiner		Immediata Causa (Final diseasa or condition rasulting in death)	. METAST						1	Onset and Death 4 MonTHS.
L	7 5	ner		Due to (or	as a consequence of)					2	
,00	be executed ician and buriel-transit	i Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of):								
× 68760,	the the	Medical									
S. Box	the attenthed for u	siciar	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						tobecco use co	ntribute to	o the cause of death?
, P.O.	es that the de igned by the be detached	y Phy						10	Yes 2 No	3 Prol	bably 41 Unknown
Division of Vital Records,	lew requires as been sign 2 should by	Completed by Physician/Me							an autopsy rmed?	av:	are autopsy findings ailable prior to mpletion of cause death?
A R	The lew cate has	S					He !	10	Yes 2 No	10	Yas 2000
VIE	2 0 2	To Be	25. Was casa referred to medical axaminer?	Hospital: 12 Inpatient 2 E	ER/Outpatient 3□ D	OA Oth	er	ath <i>(Check only d</i> Ioma 5 ☐ Resi		ar (Snacih	W1
ion of	ilng Ph After thi funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	·	28c. Injur Wor		7	how injury occur		<i>y</i>
Divis	s after de if Directo ad in by th	Certific	3 Suicide 6 Could not be detarmined		ma, farm, street, factor	y, office		28f. Location (. City or Tot		er or Rura	al Route Number,
		edical Certification:		hysician: To the best of my know miner: On the basis of examinati and manner stated.							
•	To the Total	2	29b. Signature and titla of certifier	Vani le	7 29	A -	e number		AUGUST		
	10		30. Name and address of person who	completed cause of death (Item M 0, N H C	BALTO.		2113	3			
	Stat Registra	.6	31. Data filed (Month, Day, Year) AUG 0 8 20	32. Registrar's Signate	b file	port	3				

the

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 2000 Month **Physician** Henry William Boffen, Sr. Aug. 4, 6:07am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1200 Swallow Ct. Arbutus Baltimore 8. Dete of Birth (Month, Day, Year) Dec. 29, 1 If Under 1 Year 5. Social Security Number ff Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1₺M 2□ F 216-09-6016 85 Yes Director 1914 Maryland Usual Residence of Decedent Hygiene. other than "natural", or items 23s or 28s-f show rent, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Swallow Ct. 21227 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried White 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendant Highway Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 7 le marked of treumatic evi Alfred Boffen Emilie Mattheiss 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 or other tr Irene E. Boffen, Wife 1200 Swallow Ct. Arbutus, MD. 21227 20b. Pleca of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 200. Pleca of Disposition (realists of completely, cremetory or other plece) Meadowridge Memorial Park 8-7-00 1 Buriat 2 Cremetion Removel from State 4 Donation 5 Other (Special) Elkridge, MD 21. Signature of Fymores, Se 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Ehter the disease, or complications that caused the death. shock, or heart feilure. List only one cause on each line. not enter the mode of dying, such es cardiec or respiratory errest, Approximate Intervet Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner sician end buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the buriel Physician/Medicai Due to (or es e consequence of): for use Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 1 No 1 ☐ Yes 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 12 Neturat 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed signed by the a d be deteched f Division of Vital Records, P.O. should page 2 certificate or Attending Physicien: funeral director, this After s efter deeth. 6 filled in

Box 68760.

death with the Meryland

Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.

Department

Baitimore, Maryland 21215-0020

To the Hospital or within 24 hours of To the Funeral D completely filled I 0

State Registrar

edical

29d. Date signed (Month, Day, Year) 8587

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

32. Reg

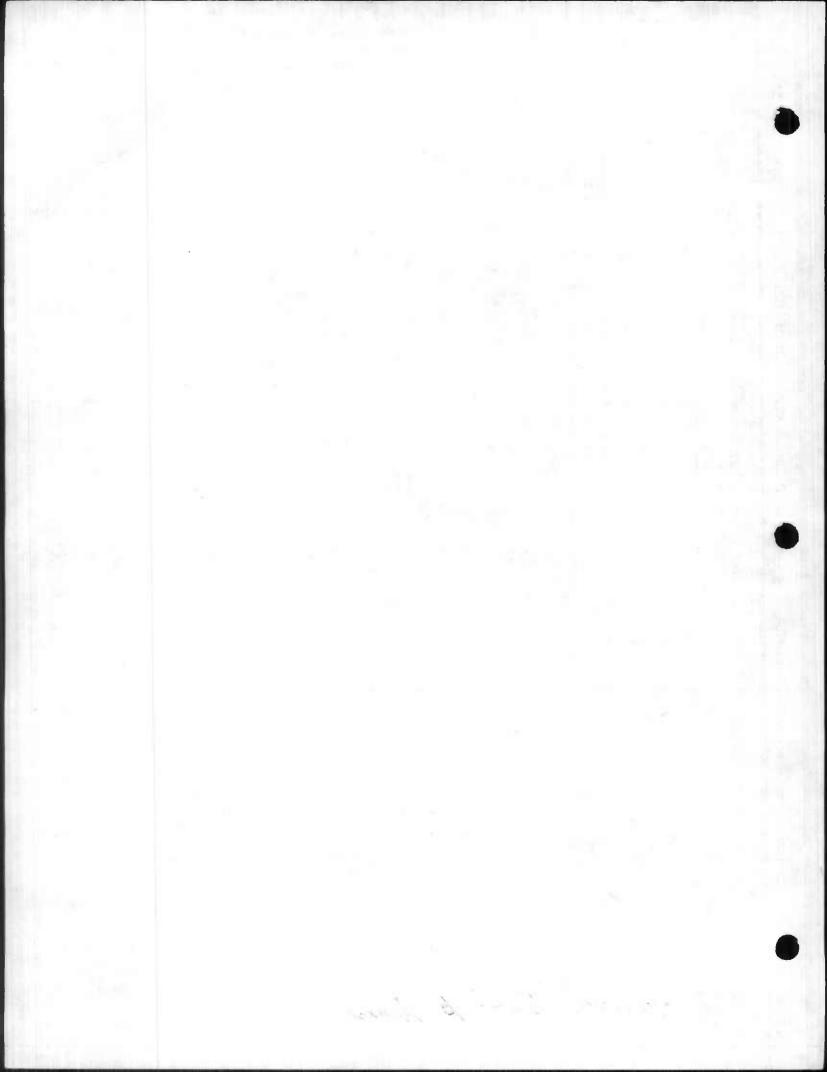
Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signeture end title of certifie

29e. Certifier (Check only one)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Dev S , Steam Month **Physician** ALLAN BERGER 44648 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Yeer 6. Sex. 1 → M 2 → F 8. Deta of Birth (Month, Day, Year) JUN.15,1908 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 92 Yrs. 212-01-1131 Director RUSSIA Usual Rasidence of Decedant with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f ahow ty Yas 2 No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 234 3209 BONNIE ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forcas? **Herna** 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black White atc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 No If Yas, Giva 21215-0020 ò 1 ☐ Yas 2 🗓 No Specify: WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Yaer or Datas: "natural" Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry other than Elemantary/Secondary (0-12) Collega (1-4or 5+) BOOKKEEPER FURNITURE i. Peges 1 and 2 should be filed w tment of Health and Mentel Hygier tant: If item 27 is marked other it ilury or other traumatic event, in Baltimore, Maryland 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be SIMON BERGER MARY ORALOVITZ 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNICE BERGER / WIFE 3209 BONNIE ROAD - BALTIMORE, MD 21208 20b. Piace of Disposition (Nema of cematary, cremetory or other place) 20c. Location - City or Town, Steta 20e. Mathod of Disposition Data 1 ☐ Burial 2 【XCramation 3 ☐ Ramoval from Stata Department of important: If any injury or HILLTOP SERVICE CORP. 8/4/00 TOWSON, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signature of Fuharal Sarvice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heef failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Immediata Cause (Finel disaasa or condition rasulting in death) useluerua /Medical Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last and Dua to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or es a consequence of): 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 3 Probably 4 Unknown I mey lea signed be det Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 DINO 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, Be 25. Wes casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yaş 1 Inpatiant 20 No 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Mennar of Death 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending after death. 1 Yas 2 No invastigation 2 Accidant 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Piace of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in Certifying Physician: To the best of my knowledga, deeth occurred at tha time, data and place, and due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licensa number 30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Print) W

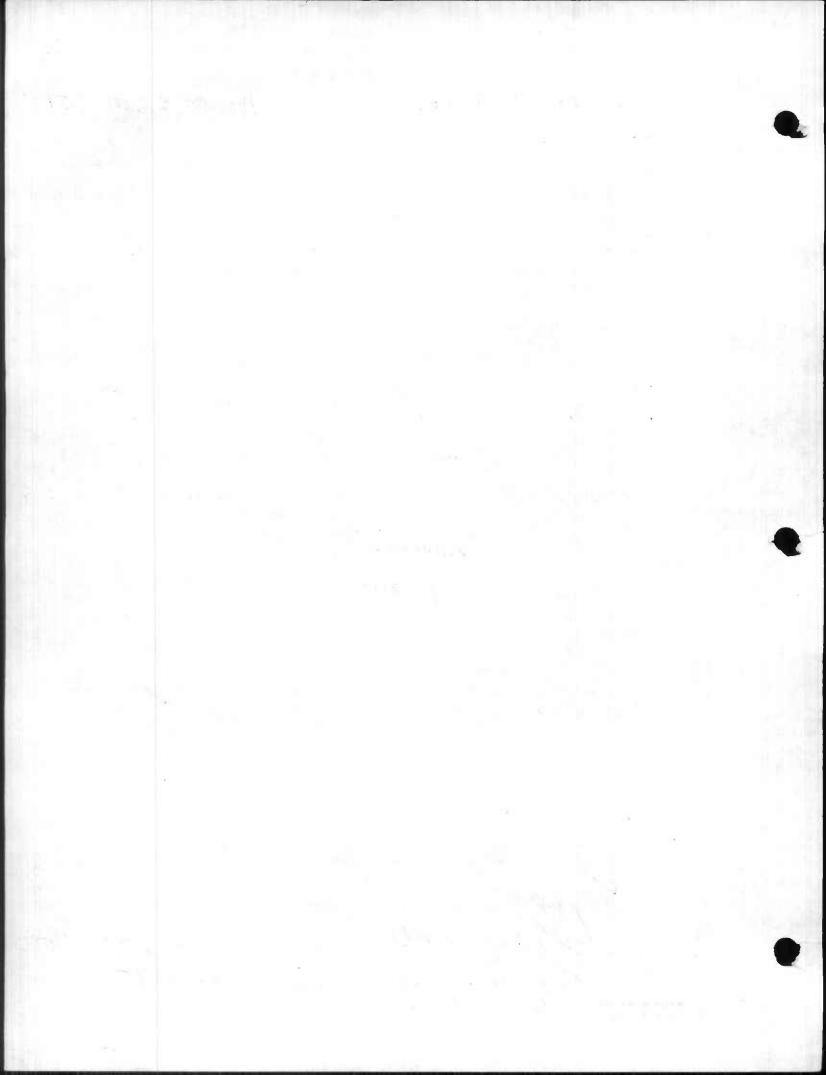
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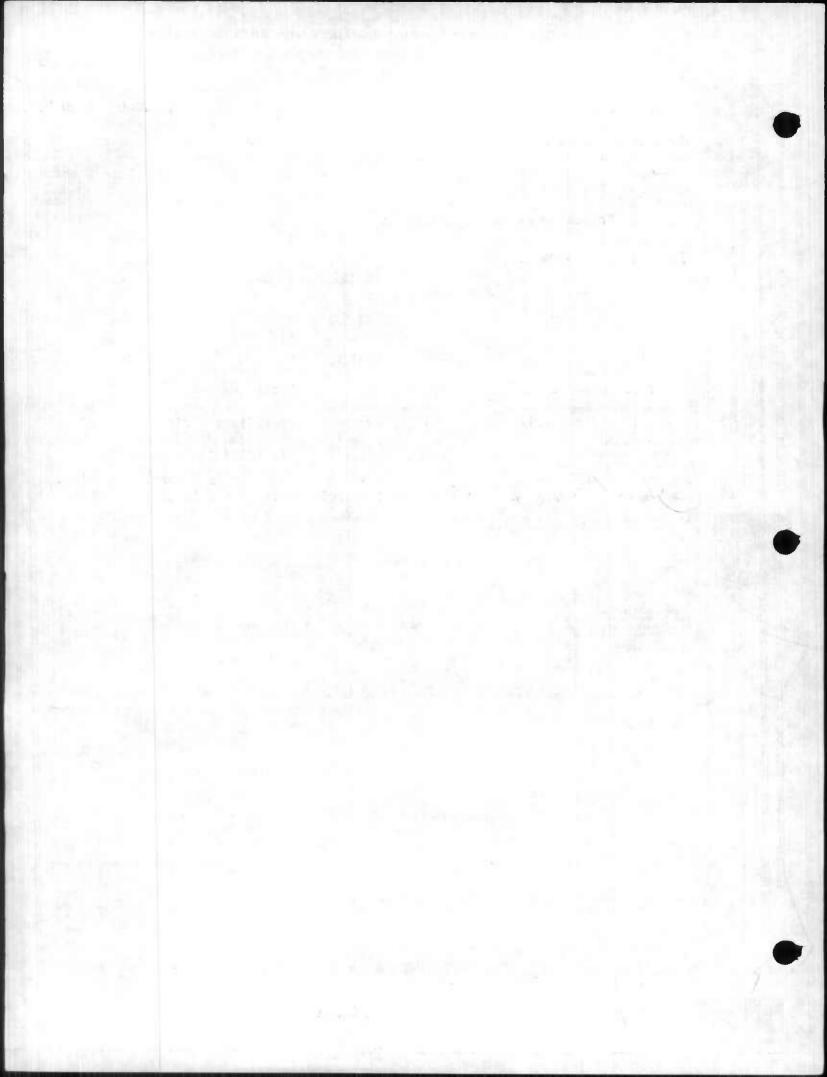
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32. Registrer's Signetura

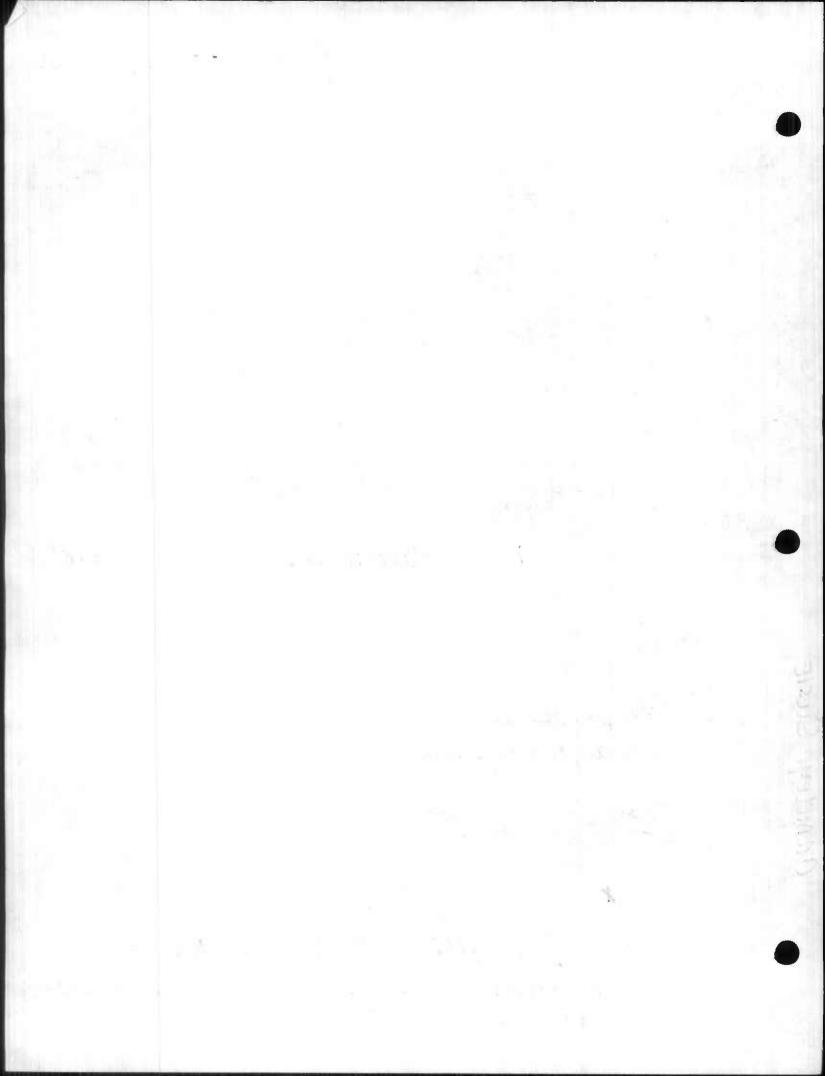


AMEND#	5 PER F.H. G787 9-1-200	State of Maryl O JAB		rtment of H			iene 0	0 24868		
Physician	1. Decedent's Name (First, Middle, Las Verita June Buc					2. Date of Deat Month July	Day	3. Time of Death 2000 4:20 P.M.		
/Medical Examiner	4a Facility Name (If not institution, give Adventist Hospita		The		4b. City, Town, or Takoma F	Location of Death	4c. County of	of Death		
Funeral Director	5. Social Security Number 6. Se	7. Age (In)	yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birth		9. Birthplace (State or Foreign Country)		
death with the Menyland ms 23s or 28s-1 show result to notified at	Usual Residence of Decedent 10e. State 10b. County MD Prince G		City, Town or Loc					10d. Inside City Limits 1 [又 Yes 2 □ No		
uth with the Meryls 23s or 28s-1 sho list be notified at ral Director	10e. Street and Number	A - 4 #11		10f. Zip Code		10	og. Citizen of W			
5 22 5	7959 Riggs Road, 11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No if Yes, Give Year or Detes:	If	20783 /as Decedent of H Yes, specify Cub ☐ Yes 2 □ No	lispanic Origin? (en, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		A , - American Indien, k, White, etc. Black		
	15. Decedent's Edi (Specify only highest gred Elementary/Secondary (0-12) 1 2	(Give h	ent's Usuel Occup ind of work done O NOT use retire	during most of wi d)	orking	16b. Kind of Bus				
Baltimore, Maryland 2121 permit. Peges 1 and 2 should be filed within Department of Health and Manciel Hygiene. Important: It ferm 27 is marked other than 's ny injury or other traumatic event, in the page. To Be Compil	17. Father's Name (First, Middle, Last) Charles John Buc				18. Mother's Na Rebeco	faiden Sumeme	9)			
e, Mai 1 and 2 sh Health and em 27 le m other traum	19a. Informant's Neme/Relationship (T. Kwesî Wood - Co. 20a. Method of Disposition	usin	13717	l vy Woo	d Lane,	Silver Sp	oring, h			
nit. Pages artment of ortant: If it injury or of	1 ☑ Burial 2 ☐ Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify,	00 - 0	Gate of			8/11/00	Wheator	•		
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Physician /Medical Examiner Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Anh	yth no o (or as a consequence o (or a consequence o (or a conseque	uence of):				Interval Between Onset and Death		
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Division of Vital Records, P.O. Box 68 to Attending Physician: The lew requires that the death certificat after death. Director: After this certificate has been signed by the attending plain by the funeral director, page 2 should be detached for use as the trification: To Be Completed by Physician/Med	Breust Cu	n Cer				24e. Was all perform	n eutopsy ned?	24b. Were autopsy findings aveilable prior to completion of cause of death?		
Vital Fiscion: The certificate irector, pag	25. Wes case referred to medical examiner? 1 Yes 2 No	Hospitel: Innation	2 C C S/Outpotions	all DOA OH	ner:	eath (Check only on		ve (Snaaihu)		
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Divisit To the Hospital or Attent within 24 Hours after deeld completely filled in by the Medical Certifical	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	ecify)			City or Town	, State)	er or Rural Route Number,		
To the Hospital within 24 hours of the Funeral I completely filled	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exam end menner stated.		estigation, in my	opinion, death occ	curred at the time, da	ate and plece, a	and due to the cause(s)		
To within	29b. Signeture end title of certifier				3937	2 J.	uly 2			
8	30. Name and address of person who c	ompleted cause of death (Item 23af (Type, F	Print) CASH Suit	19 32	silvers	Par	md 20901		
State Registrar	31. Date filed (Month, Day, Year) AUG 0 8 20	32. Registrer's Si	ignature &	Span	6					



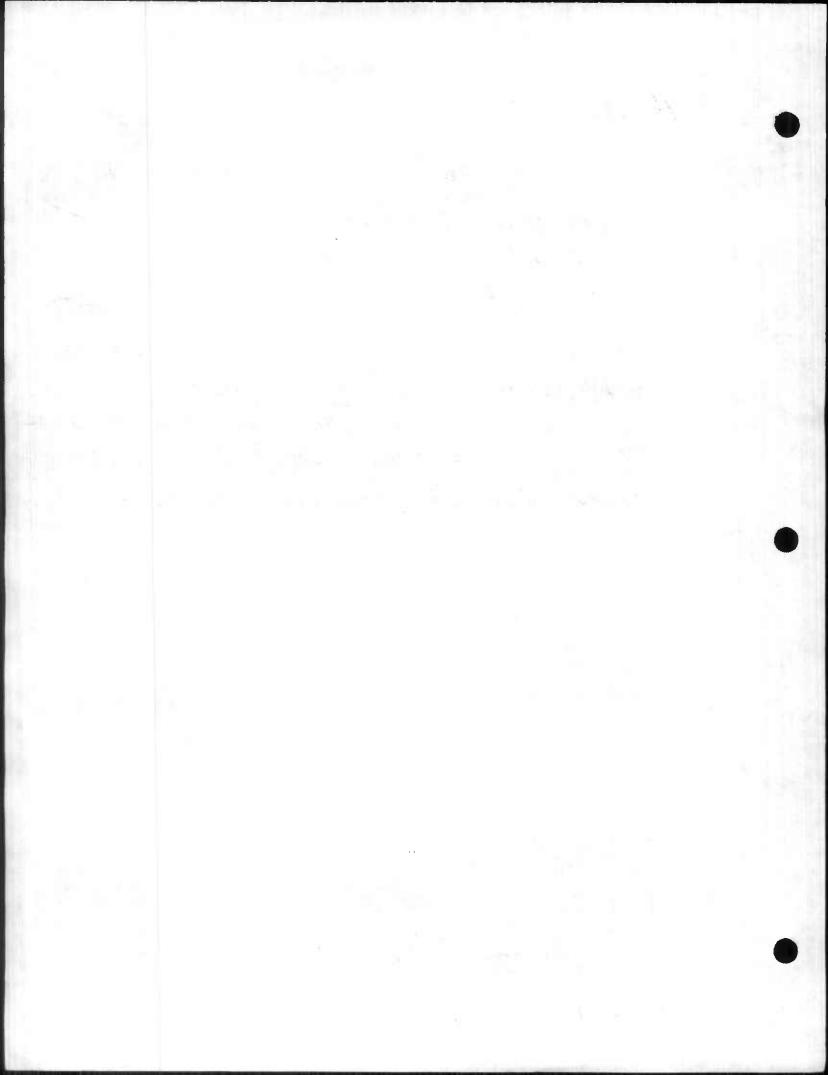
State of Maryland / Department of Health and Mental Hygiene 00 21.000

amend item	per verbal response G786 8/8/00 yg Certificate of	Death	Reg. No.				
Division	Decedent's Neme (First, Middle, Last)	2. Date of Dea					
Physician /Medical	Susie Ella Crawley	AUGUST	3, 2000 Year 19:10				
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
	St. Agnes Hospital	Baltimore	n/a				
Funeral Director	5. Social Security Number 217–22–7863 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 1 M M 2 X F 93 Yrs.		(, Year) Country)				
. pu	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. inalde City Limits				
with the Maryland te or 28a-f show te or Atthest at			1 X Yes 2 □ No				
vith the Mar t or 28s-f a	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?				
Well to the second	2515 North Ellamont Street 2	1216	USA				
ma 2;	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of						
21215-0020 within 72 hours after death v glene, retar hardrail Examiner must be Modeled by Funeral completed by Funeral	3 X Widowed 4 □ Divorced Yeer or Dates:	Hispanlc Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.) Specify:	Black, White, etc. Specify: Black				
od within 72 ho yglene. The Medical II. The Medical III.	15. Decedent's Education 16a. Decedent's Usual Occur	ipation	16b. Kind ot Business/Industry				
215	(Specify only highest grade completed) (Give kind of work dont life. DO NOT use retire the complete of the com	ed) most of working					
CA DEPT N	7thGrade Dietary He	lper	Baltimore City Hospita				
be filed tal Hyging doubler avant, I	17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)				
Vlar Menta M	Granderson Talley	Maggie P. Ma	son				
Maryland d2 should be file th and Mental Hy 7 is marked oth traumatic avant To Be C		et and Number or Rural Route Numbe	r, City or Town, Stete, Zip Code)				
CENL	Maggie Jones 3106 Leeds S	treet Baltimo	ore,MD 21229				
of Hear	20a. Method of Disposition 1	ace) Dete	20c. Location - City or Town, State				
Page nent or int: If iny or	4 Donetion 5 Other (Special) MD National Memo	rial Park 8/10	Laurel, Maryland				
Baltimore, permit. Pages tal permit. Pages tal important of Heal important: If item? any Injury or other page.		ress of Facility Nutter Fun nns Falls Pkwy	eral Homes, Inc.				
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dy shock, or heart tailure. List only one cause on each line.		rest, Approximate				
Physician	shock, or heart tailure. List only one couse on each line.		Intervel Between Onset and Death				
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Examiner	disease or condition resulting in death) Due to (or es a consequence ot):	7110	Kars				
je de la companya de							
60, be executed cian and burlat-transit	Sequentially list conditions Due to (or as a consequence ot):						
executary and and riat-tray	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury						
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Geath death death death	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse of	iven in Part I. 23b. Did t	23b. Did tobacco use contribute to the cause of death				
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Vital Records, P.O. Box idea: The law requires that the death cer certificate has been signed by the attendir rector, page 2 should be detached for use be Completed by Physician/A	Coronary Artery Disease	24a. Was	en autopsy rmed? 24b. Were autopsy findings evailable prior to				
w require to been si should	wondy Artery Visease	perior	rmed? evailable prior to completion of cause of death?				
I Rec The law ate has b page 2 s		101	/es 2 1 No 1				
Vital I	25. Was case reterred to medical	26. Place of Death (Check only o					
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Phys Phys rithis and di			now injury occurred				
On On On On On On On On On On On On On O	1. Defetural 5 Pending (Month, Day Year) Injury W 2 Accident investigation M 1[ork? □ Yes 2 □ No					
isio thandli death. ctor: A y the fu	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28t. Location (5	Street and Number or Rural Route Number,				
S PARTE TO	4 Homicide determined building, etc. (Specify)	City or Tox	m, Stete)				
Hospital 24 hours Funeral fely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the	time, date and place, and due to the	cause(s) and menner as stated.				
	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my one)	opinion, death occurred at the time,	date and place, and due to the cause(s)				
within to the comple	29b. Signature and title of certifier / 29c. Lices		29d. Date signed (Month, Day, Year)				
F 3 F 8							
	1000 - 1100	1010	144037 3, 400				
1/1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1~ Zail.	tuqust 3, 2000 nore, mp 21229				
1			1010,111 01009				
State Registrar	AUG 0 8 2000 Server & Spork	2					



Heather Colleen Carroll Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Montal Hygiene.

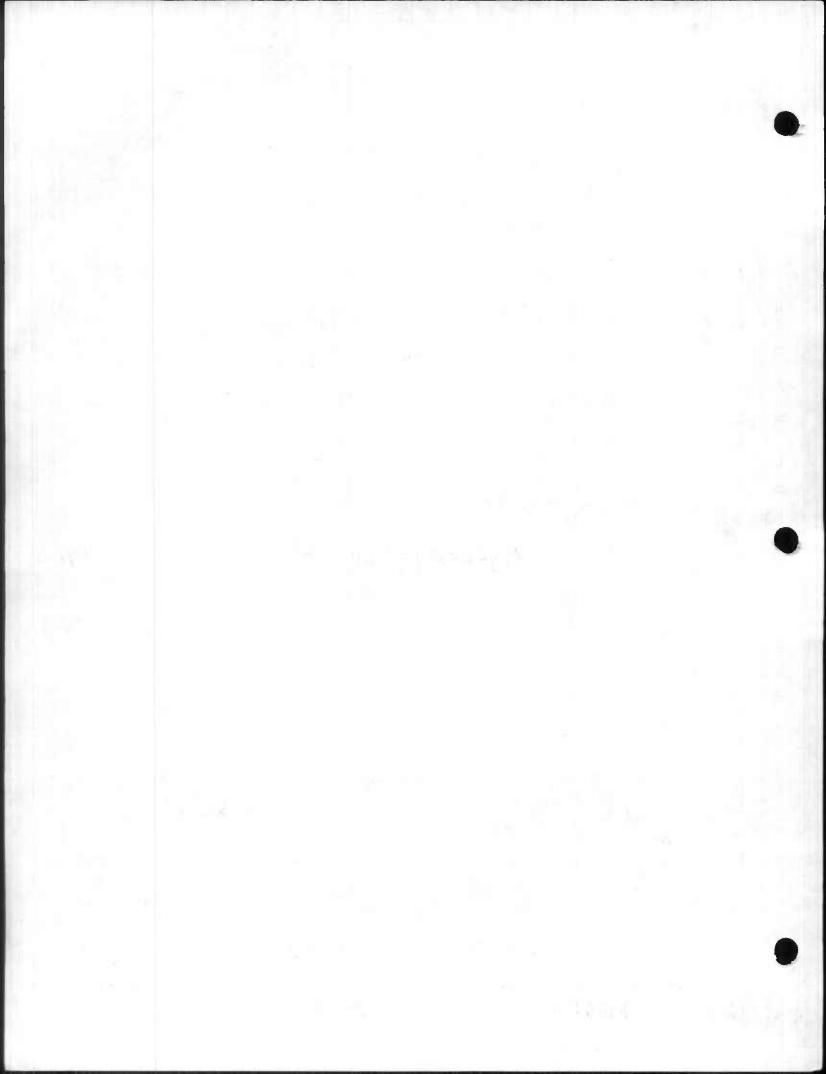
AME	END	ITEMS: #23 PART I,	State of Marylan II, 27, 28A-I	d / Departme PER MEO F Certifica	G786 8-10-00 ate of Death	WR.	giene Reg. No.		870	
Physic /Med	lical	1. Decedent's Neme (First, Middle, Lasi	COLLEEN	CARRO		2. Date of De Month July r Location of Deat	27, 2000	Yeer 05:	ne of Death	
Exam Funera Directo	1	4e Facility Name (If not institution, give Johns Hopkins 5. Societ Security Nymber 8. Se	Bayview Medic		Balti der 1 Year If Under 24 Hi	MOre 8. Dete of Bir	N	9. Birthplace (St	eta or Foraign	
		Usuel Residence of Decedent 10a. Stete 10b. County MD. BALTI	MORE I	y, Town or Location	2.K		2-)11		da City Limits	
3a or 28a	Funeral Director	10e. Street and Number	OR TERR.	-	2/2 22		10g. Citizen of V	What Country?		
5-0020 72 hours after death with the Maryland natural, or itema 23e or 23a-f show	by Funer	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	It Yes, s	cedent of Hispanic Origin? pecify Cuben, Mexican, Pue	Specify Yes or Norto Rican, etc.)	14. Race Biec Specify	e - American Indie k, White, etc.	n.	
T 5	Completed	15. Decedent's Edi (Specify only highest grad Elamantery/Secondary (0-12)	ication	16a. Decedent's U: (Give kind of life, DO NOT	work done during most of w	orking	16b. Kind of Bu	v. STDA	e F	
riand	To Be Co	17. Father's Name (First, Middle, Last) HARRY W	EIMER	CITO	18. Mother's N	ama (First, Middla	Row L	, ,,,,,		
2 2 all 2		19e. Informent's Neme/Heletionship (7)	EIMEL 20b. P	117 Plece of Disposition (A	ENTNOL Jumper of Jumper of Jumper of Jumper of	TERR. Dete	BALTE		21222	
Baltimore permit. Pagas 1. Department of He Important: If ther any injury or oth		1 Buriel 2 Cremetion 3 II 4 Donetion 5 Other (Specify, 21. Signature of Feneral Service Licens	Removal from State	emetery, cremetory of	CREMETORY	July 3/ 1 2600	BALT	o. NO.		
		23a. Perl1. Entar the disease, of shorp shock, or heart failure. List only o	licetions that caused tha deet ne ceuse on each line.	Do not enter tha m	FMANN-Jode of dying, such es card	KARDA ec or respiretory e	BAL	Approximaterve	21224	
Physician /Medical Examine		Immediate Cause (Finai diseese or condition rasulting in death)	θ	OTIC INTO						
18760, ceta be axecuted physician and the bunel-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaase or Injury	b. Due to (or es e consequenca of):							
BOX 68760, daath cartificata be as e attending physician d for usa as the buria	n/Medicai	thet initiated events resulting in death) Last	Due to (or es e consequenca of):							
0 8 4 8	Physician/M		anditions contributing to death but not resulting In the underlying cause given in Part i.					23b. Did tobacco use contribute to the cause o		
o 2 5 8	by	COCAINE USE				24a. Wes	Yes 2□ No s en eutopsy ormed?	24b. Were euto	opsy findings	
Rec	Completed					}O	Yes 2□No	of death?		
Of VITAL Physician: The this cartificate ral director, page	Be	25. Wes casa referred to medical examiner?	Hospital:		Othor	eeth (Check only				
on of Ing Phys After this	ation: To	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation	1 □ Inpatient 2X 28e. Dete of Injury FO(1001 Dey Year) 7-27-00	28b. Time of A FOUNDS: M	28c. Injury et Work? 1 Yas 2 XNo	28d. Describe	how injury occur			
2 2 4 2 5	Certification:	3 ☐ Suicide 6 ♣ Could not be determined	28a. Placa of Injury - At he building, etc. (Specifi FOUND		ory, office	28f. Location City or To BALTO.	(Street end Numb wn, Steta) 105 CO., MD	per or Rurel Route 5 DUNBAR •	Number, RD.	
To the Hospital or within 24 hours affa To the Funeral Dir completally filled in	edicai		sicien: To the bast of my kno- ner: On the basis of examine end menner stated.						use(s)	
To the vithin To the	Me	29b. Signature end till a Certifier	- 14	10	29c. License number		29d. Date signe	d (Month, Day, Ye	Mar)	
		30. Nemerend address of person who co			O.C.M.E.	7.1.	Jul		00	
Ši Regis	tate trar	JOSE H PESTANER, 31. Dete filed (Month, Dey, Year) AUG 0 8 2000	M. D. 32. Registrer's Signe		n Street, Ba	Ltimore,	Marylan	a 21201		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dominic Cangelosi August 2, 2000 4:35 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7508 Sudbrook Road Pikesville Baltimore Birthplace (State or Foreign Country) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Yea Sept. 30, 5. Social Security Number 6. Sex 1⊞ M 2□ F 7. Age (In yrs. last birthday) O. 1918 Louisiana **Funeral** Days Hours 214-30-5263 Director Usual Rasidence of Dacedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 7508 Sudbrook Road Funeral 21208 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marifal Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Saltimore, Maryland 21215-0020 b 1 ☐ Yes 2K No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Modern Manufacture 8th Presser Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Hestith and Mental Giuseppe Cangelosi Maria Petarra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other trains Lina Cangelosi (Wife) 7508 Sudbrook Road, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Burlel 2 Cremation 3 Removal Iron State
4 Donation 5 Other (Specify) Encombment Department of Important: If any Injury or Druid Ridge Mausoleum 8/5/00 Pikesville, Maryland 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee ellner MO0333 8728 Liberty Road, Randallstown, MD 23a. Find Entail the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one causa on each line. Approximate Intarvat Batween Onset and Death **Physician** /Medical tmmediate Causa (Final MYELODYSPLASIA

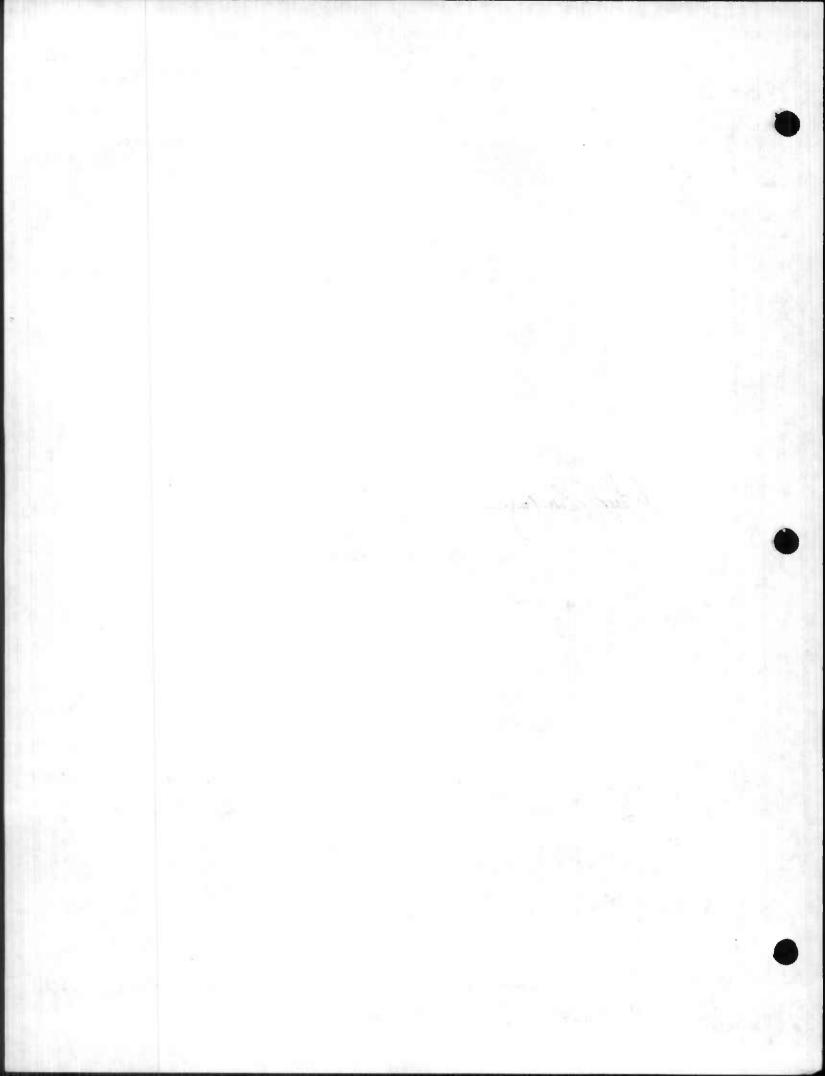
Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Box 68760. Physician/Medical the Due to (or as a consequenca of): USB 1 P.O. 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Wera autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 25. Was casa raferred to medicat examiner? Be 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, straet, lactory, office building, etc. (Specify) à 4 ☐ Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22 S. GREENE ST. of person who compated causa of death (Item 23a) (Type, Print) UNIY OF MD HOSP. BALTO MD. 21201 B. HEYMAN 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 24872

		Certificate of Death Reg. No.												
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Examin		4e Facility Neme (If no			um <i>ber)</i>				4b. City, To	wn, or Lo	cation of Deet	h 4c. Cou	inty of Deeth	
4 1		9916 Golf Course RD Unit 71 Ocean City												
Funeral Director		5. Sociel Security Number 6. Sex 1 Months 1 Mont						8. Date of Bir (Month, De 10/22	th by, Yeer) 2/1920	9. Birth Cou PA	plece (Stete or Foreign ntry)			
g .		Usuel Residence of De- 10a, State 10	b. County		10	c. City, Town or I	acation							10d Incide City Limite
tor death with the Manya Rems 23e or 28e-f shor	otor		orceste	er	10	Ocean C								10d. Inside City Limits 1 ☐ Yes 2 💢 No
4 th	Directo	10e. Sireel and Numbe	r				10f. Zi	p Code				10g. Citizen	of What Cou	nlry?
h wi	70	9916 Golf (Course	RD U	nit 73		2	1842				USA		
	y Funer	11. Marital Status 1 Never Married		If Yes, G	orces? 2 No live	in U,S. 13	Was Dece If Yes, spe	cify Cub	lispanic Ori an, Mexicer Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, Beily: Whit	etc.
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of the stand of th		20e. Method of Disposit	tion		2	Ob. Place of Disp			001	1	Dete	20c. Locati	on - City or T	own, State
Baltimore, sernit. Pages 1 a Appartment of Hea mportant: If Hean iny Injury or othe inse		1 XBuriel 2 C 4 Donetion 5 C	Other (Speci	ty)	State	cometery, cr	11 Me	moria	alGar		8/10/0	0 Balt	imore,	MD
Ball Department of the control of th		21. Signetum of June	Service Lice	ustre.					iss of Facili ge Fu		I HOME	108 Wi Berlin		Street 21811
		23a. Pert1. Enter the d shock, or heert fe	iseese, or con	plications that	caused the	death. Do not e	nter the mo	de of dyir	ng, such as	cardiec o			.,	Approximete Intervat Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)		0	Acute 1	Myscanchia	1 Dr	Genc						Onset end Deeth Mmutes
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death o	lan													
. 0 0 0	yslo	Part II. Other significan	nt conditions	contributing to	death but no	ot resulting in the	in the underlying cause given in Pert I. 23b. I					23b. Did tobacco use contribute to the cause of de		
datac	by Physician	Dikted	Condio	myspet	shy						1 🗆	Yes 2 h	io 3 Pro	Unknow
require been should	eted	Pacemal	ken									an eutopsy ormed?	8.	Vere autopsy findings veilable prior to ompletion of cause I death?
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ysicien: The section of director, page	Be	25. Wes case referred examiner?	to medical	0						e of Deetl	(Check only	one)		
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Sing Pl	.io	27. Manner of Death Naturet 5	Pending	28e. Dete (Mo	e of Injury onth, Dey Ye	ar) 28b. Time Injury		28c. Inju Wo			28d. Describe	how injury or	curred	
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DIVISION O To the Hospital or Atlanding Ph Within 24 hours after death. To the Funeral Director: After th To completely filled in by the funeral	edical	29a. Certifier (Check only one) 2	Certifying Pi Medical Exa	miner: On the	e best of m basis of exa nner steted	y knowledge, dee mination and/or	th occurred	d et the ti	me, date er opinion, dea	nd plece, ath occurr	end due to the ed at the lime	ceuse(s) end date end ple	d menner es ca, end due	stated. to the ceuse(s)
o this	Me	29b. Signature and little	of certifier				25	c. Licens	se number			29d. Dete si	gned (Month	, Day, Year)
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1		30. Neme end eddress	- 1	completed cau	use of death		0		0 -	RI	.2 6.	4-1 7	2,-1	Md 21811
		24 Date filed (Alenth Day Year) 22 Decistor's Signature							1000 2(01)					
Sta	ate	31. Dete filed (Month L	0 8 200	n 32	Logisti el S	L A	1	- /	1					



State of Maryland / Department of Health and Mental Hygiene 24873 Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** Vivian H. Crawford 9:25 pm August 3,2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner HRUNDEL HOSPITAL GIEN BURNIE AA COUNT NORTH If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M XXF 249-09-1307 80 Yrs 1919 10, South Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County ral', or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 USA 1441 Washington Avenue Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 (Z)No If Yes, Give Yaar or Datas; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or White 1 Yes 2 No Specify: þ 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 18. Mother's Neme (First, Middle, Maiden Surneme) 17, Fathar's Nama (First, Middla, Last) Be John T. Hutchinson Louise Gossett 10 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health el Important: if item 27 is any injury or other traughter. . Linda S. Crawford (Daughter) 1441 Washington Avenue, Severn, MD 21144 20b. Placa of Disposition (Neme of cematery, cremetory or other plece) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 08/07 1 Burial 2 □ Cremation 3 □ Removal from Stete Maryland Veterans Cem. Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hardesty Funeral Home, P.A. alu 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the offseese, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiec or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner physicien and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated avants resulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 □ ER/Outpetient 3 DOA edical Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and titleyef confife 29d. Date signed (Month, Day, Year) MI who completed cause of deeth (Item 23a) (Type, Prifit 30. Neme and address of 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

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OCAWFORD VIULA Baitimore, Maryland 21215-0020

Pages 1 and 2 should be nant of Health end Mentel

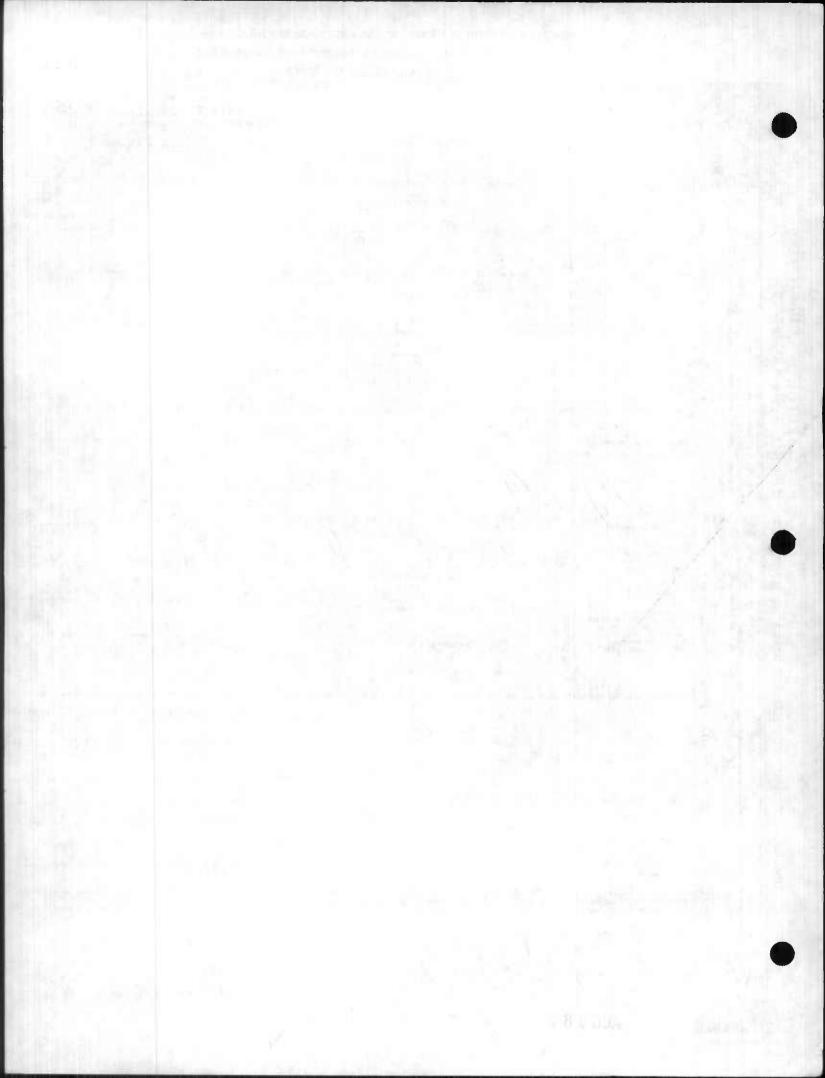
the death certificate be axecuted

68760

Box

P.O.

Division of Vital Records.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U AMENDED ITEMS 18, 19a, 19b PER INFORMANT G786 8/31/00 AH Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** Kenneth Raymond Davis July 29, 2000 /Medical 11:15 P.M 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Prince Georges' Community Hospital Cheverly Prince Georges 7. Age (In yrs. last birthday) | Hunder 1 Year | Hunder 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** 1☐M 2□ F 187-221323 70 Director Dec. 29,1929Pennsylvania Usuai Rasidenca of Dacedent 10s State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 √ Yas 2 No Directo MarylandPrince Georges Upper Marlboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 13526 New Acadia Lane 20774 Norms 23a United States 12. Wes Decedent Ever in U,S. Armed Forces? 1XDYes 2 □ No If Yes, Give Yaar or Detas: 14. Race - American Indian, 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. hours after 1 ☐ Never Merried 2 Married 21215-0020 5 1 Yes 2 No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry filed within 7 Hyglena. Elementary/Secondery (0-12) College (1-4or 5+) Union 12th Grade Metro Tranist Fed. Credit Finance Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 18. Mother's Newton Davis

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MARY SUE NEWTON DAVIS s 1 end 2 should be fill I Heelth and Mental H tem 27 is marked out Ulysses Davis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13526 NEW ARCADIA JANE, UPPER MARLBORD, MD 20774
1508 Strady Glen By , Foresty The, ND 20747 19a. Informent's Neme/Reletionship (Type, Print) Vinian Davis VIVIAN DAVIS nt of Heelth a: If Item 27 is 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Peges 1 1 Buriel 2 □ Cremetion 3 □ Removel from Stete × Department of Important: If any injury or page. Fort Lincoln Cemetery 8/3/00 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Latney s Funeral Home, Inc. 21. Signaturus Funeral Servica Licansee CC0348 3831 Georgia Ave., NW, Washington, DC Matrice 20011 mn 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Intervei Between Onset and Death Physician tmmediete Cause (Finel diseese or condition resulting in death) Prostate Cancer /Medical Examine Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Lest Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel
2 Accident Attending 5 Pending 1 ☐ Yes 2 ☐ No investigetion deeth 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide effer ò ă 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one 29c. License number D 46704 29b. Signatu 29d. Date signed (Month, Day, Year) and title of certifier Thousande, MD

DHMH 16 Rev 6/95

ENNE

State Registrar

MUTOMBO 31. Data filed (Month, Data (1907) 8 2 0 0 2. Registra Signature

KAN KONDE

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) KMJER PERMANENTE

31,2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death Month **Physician** 1803 2000 DANIEL L. DELOSIER, SR. Hua /Medical 4b. City, Town, or Location of Ceath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner BALTIMORE BALTIMORE ST. AGNES HOSPITAL 8. Date of Birth (Month, Day, Year) MAY 15, 1930 If Undar 1 Year | If Undar 24 Hrs. 9. Birthplace (Stata or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2□ F 70 Yrs. MARYLAND Director 213-28-4402 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MARYLAND BALTIMORE CATONSVILLE Norms 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be 508 S. HILTON AVENUE 21228 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. 1⊠ Yes 2□ No If Yes, Giva Year or Dates: 1948-1990 1 Never Married 2K Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) UTILITY COMPANY DISPATCHER 12 18. Mother's Name (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middla, Last) Mental should be CHARLES E. DELOSIER MAZIE GOVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) restituent of Health at Important: if fee 27 is a say injury or other 1 SHIRLEY A. DELOSIER-WIFE 508 S. HILTON AVENUE, CATONSVILLE, MARYLAND 21228 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-5-00 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fysical Service Coense LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 23a. Part1. Enter the disease, or complications was caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examine Prostate es the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events and the ettending physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 1 No 3 Probably 4 Unknown signed by Kenal Failure by Division of Vital Records. 24b. Were autopsy findings available prior to completion of causa of death? page 2 should Completed 24a. Was an autopsy hes 1 Yes 2 No 2 No this certificate Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 2 2 ER/Outpatient 3 DOA 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After Attending 5 Pending investigation 1 ONatural injury death. 1 Yes 2 No 2 Accident after death Director: A 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stefa) 6 Could not be 3 Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) lilled in by 4 Homicide To the Hospital
within 24 hours a
To the Funeral C edicai 1 Cortifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and titla 29c. License number 29d. Date signed (Month, Day, Year) ms D43453 of death (Item 23a) (Type, Print) 30. Name and address of on who completed cau Hospital Baltimore, Marylan V. Dixon Kilng , Jr, 32. Radistrar'a Signatura 31. Date filed (Month, State 2000

DHMH 16 Rev 6/95

Registrar

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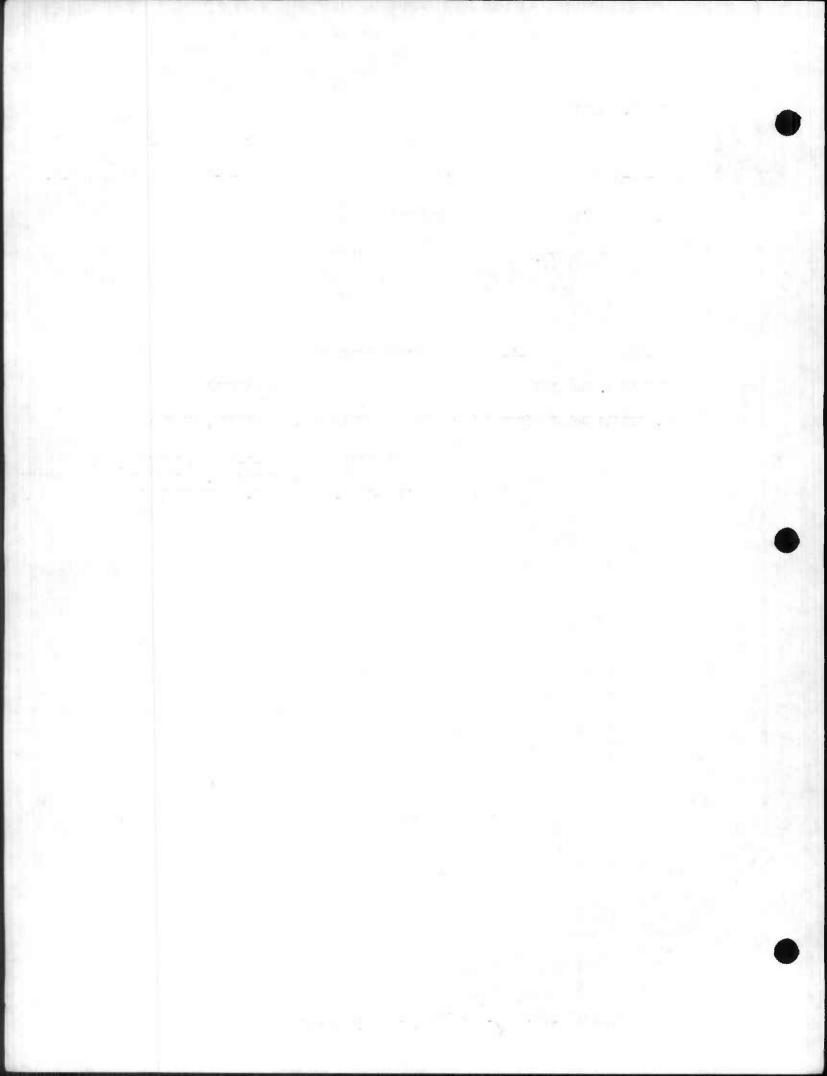
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State of Maryland / Department of Health and Mental Hygiene

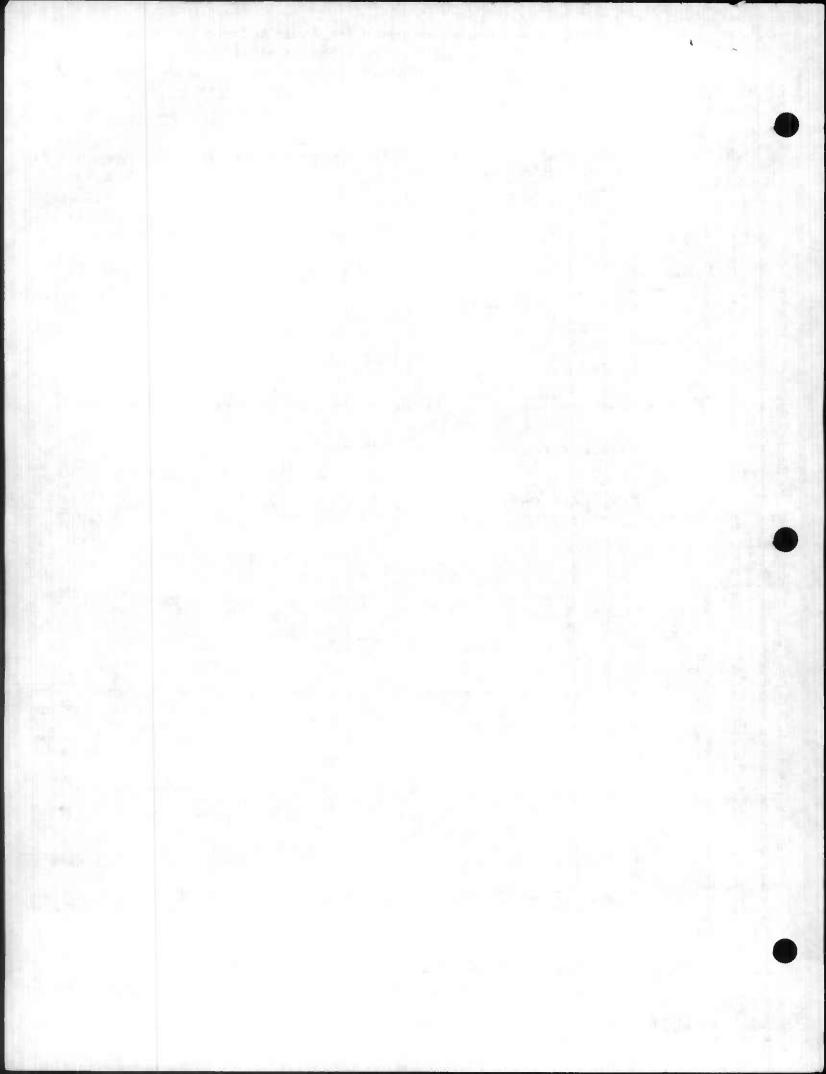
AM	END I	TEMS: 23 PART I, 2	7 PER MEO	G787 8-9	Certific	cate of	Death	,	Reg. No.	1	48/6	
		1. Decedent's Name (First, Middle,						2. Dete of De Month	ath	Year	3. Tima of Death	
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	Examiner	An Physitte - Atomic - Ald mad Impath store	giva street and number)		Maria I	4b. City, Town, or Lo	ocation of Death	4c. County	of Death		
3 (A) 1		2808 Guilfor	d Avenue	Apartmen	t # 2		BALTIMO	RE				
	uneral irector	5. Social Security Number 212-80-6864 Usuel Residence of Decedent	3. Sex 7. A 1 □ M 2\(\tilde{	ga (In yrs. last bir 39		Inder 1 Yaar nths Deys		8. Date of Bir (Month, Da 8-9-1	th y, <i>Year</i>) 960	9. Birthpl Count WASH.	lace (State or Foreign try) D.C.	
pue	E-1	10a. Stata 10b. County		10c. City, Tow	n or Location	n				10	0d. Inside City Limits	
e Maryl	72 hours after death with the Manyland natural", or items 23a or 28a-f show deat Exercises must be notified at eted by Funeral Director.	MD. N/A		BALTI	MORE	116					1 CXYes 2 □ No	
th with th		10e. Street and Number 2808 GUILFORD	AVE.		10	of. Zip Code 2122	8		lry?			
ZTZTS-00ZU d within 72 hours after des			Armed Forces 1 ☐ Yes ②☐ If Yes, Give	1 Tyes 2 No			Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	e - America ck, Whita, a /: BLA	atc.	
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id be	arked out	THOMAS H. Del	AINE				DORIS I					
Maryland d 2 should be file th and Mental Hy	2.5	19a. Informant's Name/Reletionsh DR. THOMAS DeL					t end Number or Run AVE . BALT		-			
1 and Haalth		20a. Method of Disposition		20b. Plece o	Disposition	(Neme of		Date	20c. Location			
Pages nent of	- 1	1 ☐ Burial 2 ☐ Cremation 4 ☐ Doneyon 5 ☐ Other ()		ARBUTU		y or other ple ORIAL		-7-2000	BALTIMO	DRE, N	MARYLAND	
permit. Pages 1 at Department of Haa	important: I eny injury o pnce.	21. Signature of Funaral Service L	R. J.) ou			ess of Facility VEI	RNON R.	BAILEY	FUNE	RAL SERVI	
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UIVISION i or Attending after death.	al Director: After ted in by the funeral Certification:	3 Suicide 6 Could no determine	ad 288. Piece of it	njury - At home, fa otc. (Specity)	rm, street, fa	actory, office		28f. Location (City or To		ber or Rure	el Route Number,	
Hospital or 24 hours after	To the Funeral Di completely filled in Medical Cer		Physician: To the best caminer: On the basis of and menner s	of examination an								
To the within	omple Mec	29b. Signature and title of gertifling	and memers			29c. Licen	se number		29d. Dete signe	d (Month,	Dey, Year)	
- 3	- 0	Mator	ceus)				O.C.M.E.		Aug	ist 2	, 2000	
		30. Name and address of person w	no completed cause of				reet, Balt	timore			N-MBE	
	Štate	31. Dete filed (Month, Dey, Year)		rar's Signatura				THIOTE,	HOLYYLA	KI 214	201	
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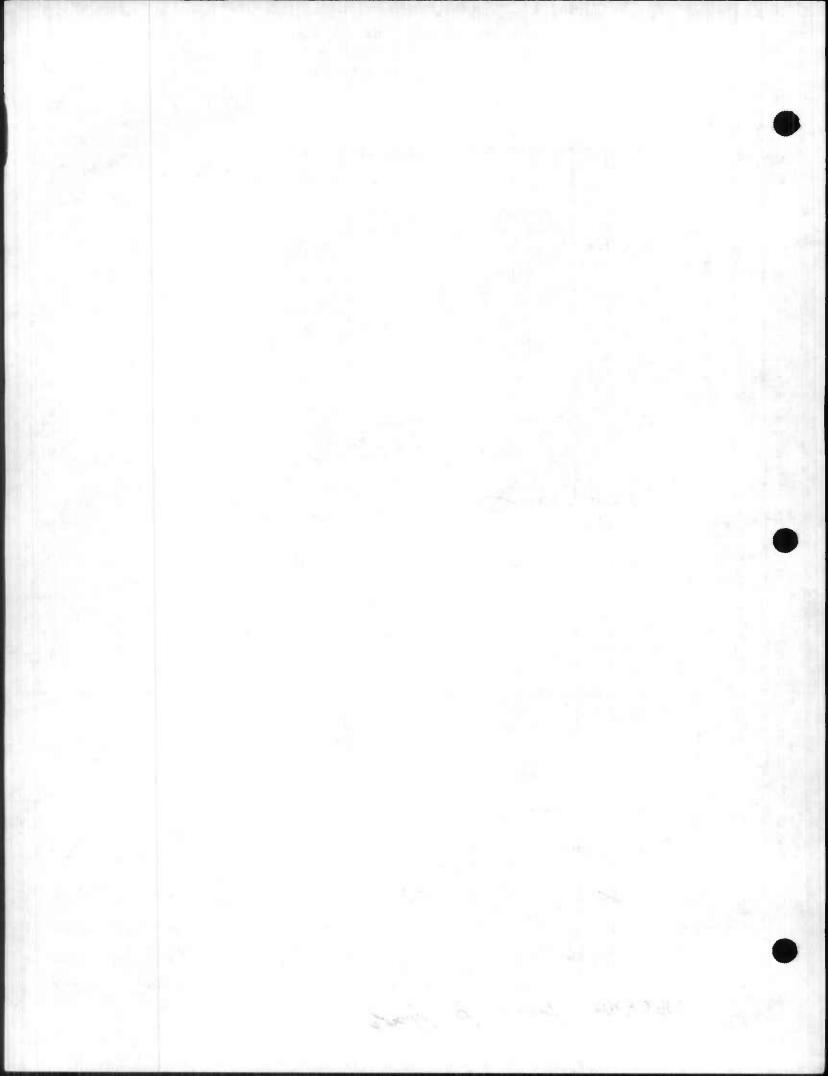
			Certificate of I	Death		Reg. No.	2401.1	
Physician	1. Decedent's Name (First, Middle, Last) Joseph Edward Eb	ile			2. Dete of Dec Month Aug. 4,	Day	3. Time of Death	
/Medical	4e Facility Neme (If not institution, give street end		T4	b. City, Town, or I			10:35 ar	
Examiner	7268 Forest Avenue			Hanove			e Arundel	
E-march 1	5. Social Security Number 6. Sex	7. Age (In yrs. lest birth	dev) If Under 1 Year	If Under 24 Hrs.			Birthplace (State or Foreign Country)	
Funeral Director	216.30.9996		rs. Months Deys	Hours Min.	Jan.11		Country) Maryland	
how	Usuet Residence of Decedent	00			pan. II	1 1993	Maryrand	
	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
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irec	10e. Street end Number	METERS III.	10f. Zip Code			het Country?		
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Funeral Director	11. Marital Status 12. Was D	ecedent Ever in U,S.	13. Was Decedent of H	lispenic Orlgin? (S	pecify Yes or No-	14. Race	- American Indian,	
F	1 Never Merried 2 Merried 1 Y	Forces? es 2 No Give	If Yes, specify Cube		o Rican, etc.)		, White, etc.	
by	3 ☐ Widowed 4 ☐ Divorced Yeer of	Give r Dates: 55-57	1 ☐ Yes 2 X No	Specify:		Specify:	White	
Completed	15. Decedent's Education	16a, [Decedent's Usual Occup	ation		16b. Kind of Bu	siness/Industry	
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Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,			
0	George Edward Eble			Madel	ine T.	Zinkar	nd	
-	19a. tnforment's Neme/Relationship (Type, Print)	end Number or Ru						
	Doris E. Eble/Wife	Ave. Ha	nover.	MD 210	76			
	20a. Method of Disposition	20b. Place of I	Disposition (Neme of		Date		City or Town, State	
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	4 □ Donetion 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee			Elkride				
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Department of Important: If sny Injury or DDCs.	1 / Wal 11 / A rock		7250 Wash	ington	Blvd.	Elkridg	ge, MD. 210	
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iffic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pl	ece of tnjury - At home, familding, etc. (Specify)	m, street, fectory, office		281. Location (S City or Tox		er or Rural Route Number,	
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	29e. Certifier Certifying Physician: To							
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	30. Name and eddress of person who completed c	augo of death flow past C	Tuno Print		/	1104	1 2000	
	Sur Ivarie and eduress of person who completed of	ause of death (fem 23a) (T	A TAX	ALE	A.J.	TIMAN	E MAD 7177	
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State of Maryland / Department of Health and Mental Hygiene 000

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Fune Direc		011110102	7. Age (In yrs. k	Yrs.	ths Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, De Dec. 12	2, 1927	Birthplece (State or Foreign Country) China		
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d 21215-0020 Glied within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene.	by Funeral	11. Maritel Stetus 1 Never Merried	12. Wes Decedent Ever in U,8 Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Yeer or Detes:		ecedent of H specify Cube s 2000	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify:	- American Indian, c, White, etc. Chinese		
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Baltimore, Nemit. Peges 1 and Department of Heelth Important: If them 27		20e. Method of Disposition 125 Burial 2 ☐ Cremetion 325 4 ☐ Donetion 5 ☐ Other (Specify	Removal from Stete	ace of Disposition of metery, crematory Pleasant	or other place		Dete 0, 2000	20c. Location - (City or Town, State		
Baltimo permit. Peg Department Important: h	once	21. Signature of Funerel Service Licen	See Victor P. Do		Charles	s L. Stev	ens Fur	neral Hon	ne, Inc. 2 MD 21230		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death **Physician** 4:40PM Katherine M. Frey August 2000 /Medical 4b. City, Town, or Location of Beath 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Catonsville Charlestown Baltimore Center Care If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 213-09-4488 89 Director Sep 25, 1910 MD Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland neat of Health and Mentel hyglene. Ansatt if Itam 27 la marked other than "natural", or items 23s or 28s-f ahow wit: if Itam 27 la marked other than "natural", or other traumatic avant, The Marginal Experiment Than notified at uny or other traumatic avant, The Marginal Experiment Than notified at 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2603 Putty Hill Avenue 21234 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: þ 3€ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) May Company Elementary/Secondary (0-12) College (1-4or 5+) Clerk 6 Baitimore, Maryland 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reinhard Gunkel Elizabeth Bernhardt 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 5535 Lanham Way Robert Frey Baltimore, MD 21206 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 8 permit. Page Department of Important: If any Injury or onca. Moreland Memorial Park Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Evans Funeral Chapel 8800 Harford Rd. Pa Parkville, /25a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical 6 months Examiner Physician/Medical Examiner The lew requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of) Box 68760. Dua to (or as e consequence of) USA AS P.O. 1 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by page 2 should b 24b. Wera eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 10 No 1 Yas 2 No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funerat Director: After this certification of the funeral director; Be 25. Was casa referred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of edical Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signet 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DHMH 16 Rev 6/95

Maiden

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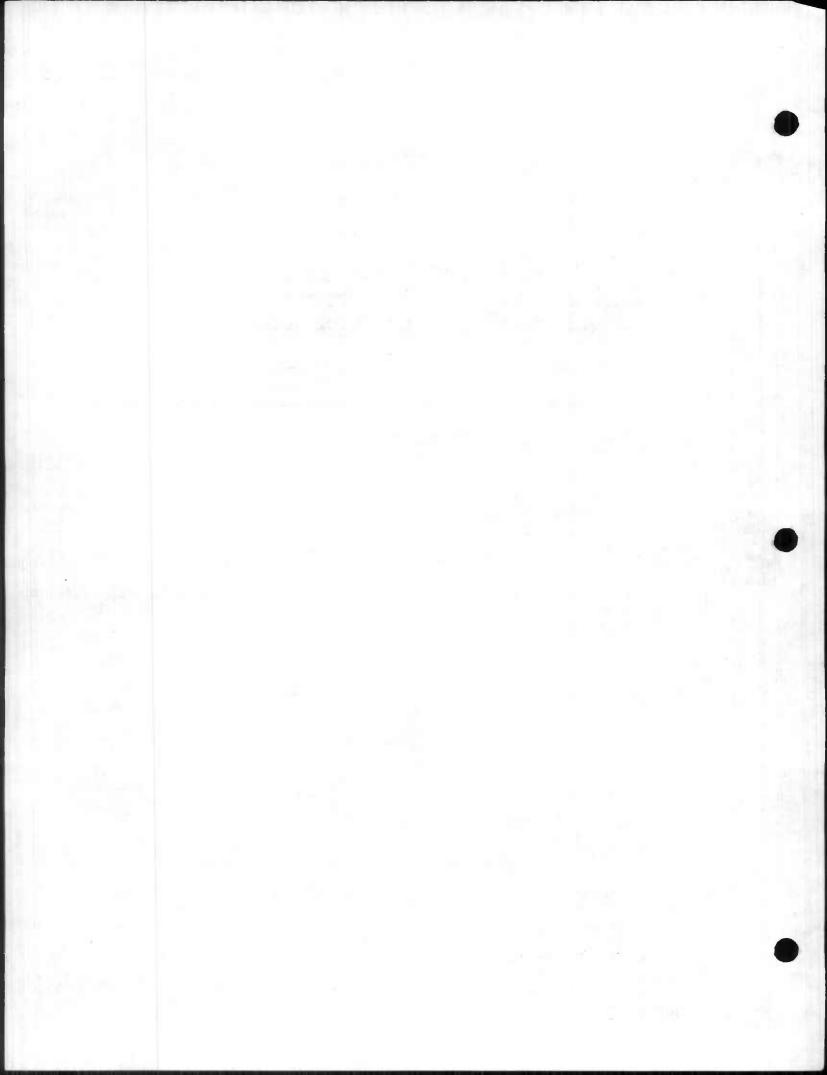
32. Registrar's Signeture

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31. Dete tited (Month, Day, Year)

AUG 0 8 2000

Choice Lane, Baltimore, MD 21228



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM 20b PER FH G786 8/9/00 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 40gust 2,2000 Thelma L. Graham 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltmore City General aryland If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye 8. Date of Birth (Month, Day, Year) Days Hours 1□ M 25 F 219-16-9470 03-09-23 VA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 Dolphin Street Apt. #1401 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) GED NA Nurses Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) William N. Kay Vines / Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4913 Truesdale Avenue Baltimore, Maryland Angela Key 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/8/00 1 Burial 2 Cremation 3 Removal Irom State 4 Donation 5 Other (Specify) Baltimore Nat; l Cem. 08-04 2000 Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21. Signati d Funeral Service Lio 21202 WM.C.March FH 1101 E. North Avenue 23a. Part LEntar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) Ruminua HINSIUM equence of): multi-

Physician /Medical Examiner

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Division of Vital Records,

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Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 MUnknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29e. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely

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Registrar

31. Data filad (Month, Day, Year) AUG 0 8 2000

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me and address of person who completed cause of death (flem 23a) (Type, Print)

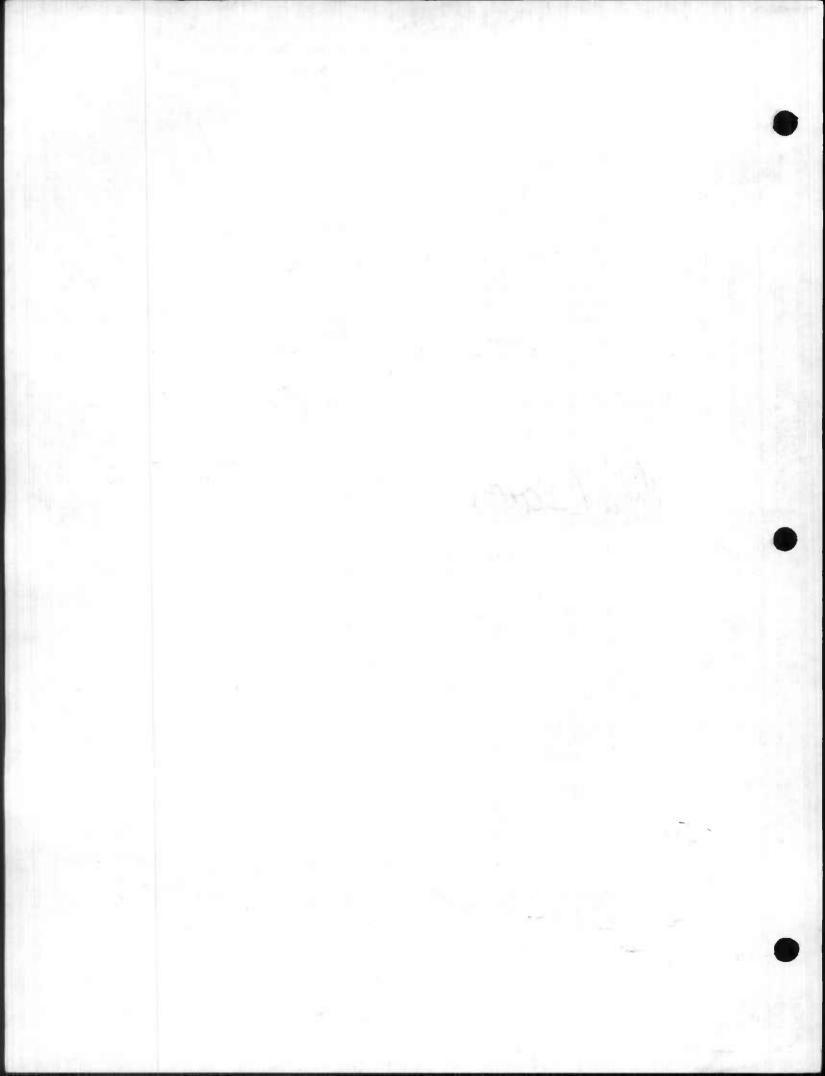
29b. Signature and title of cartifiar

uaguda, 32. Registrar's Signature maryland General Hospital

29c. License number

29d. Date signed (Month, Day, Year)

8/2/00



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#19B PER F.H. G786 8-22-2000 JAB 3 Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month 835pm William M. August 2000 4b. City, Town, or Location of Death 4c. County of Death 43 Facility Name (If not institution, give street and number) tranklin Square Hospital center Baltimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 18, Birthplace (State or Foreign Country) NY 7. Age (In yrs. last birthday) Months Days Hours NUM 20 F 552-02-5514 5 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 3509 Losrac Court 10f. Zip Code 10g. Citizen of What Country? 21234 USA 14. Race - American Indian, Biack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Mortes 2 No Marines If Yes, Give Year or Dates: 60-62 1 Never Married 2 Married 1 ☐ Yes 2000 Specify: White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electronics Tech. Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 The Court, Parkville Maryland 21234 19a. Informant's Name/Reletionship (Type, Print) Elaine P. Honeycutt / Friend 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removel from State Irondequoit Cemetery August 10, 2000 Irondequoit, NY 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Lioupses 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) MYOCARDIAL INFARCTION Due to (or as a consequence of): PRITENSION Due to (or as a consequenca of): Due to (or as a consequenca of): ARUDIF C00 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes PNo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

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To the Hospital within 24 hours a To the Funeral C

Box 68760,

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Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Be Completed by

25. Was case referred to medical examiner?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 11 Matural 5 Pending 1 Yes 2 No investigation 2 Accident

6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

du Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARNI, MA

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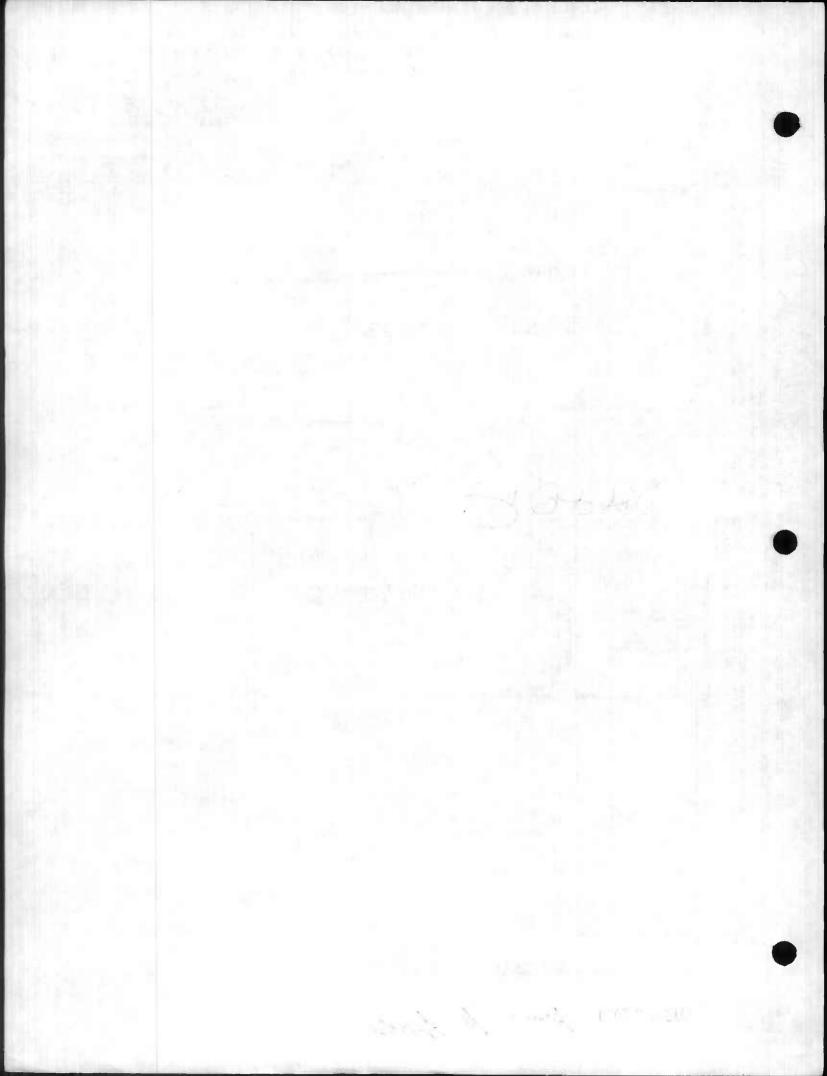
Registrar

31. Date filed (Month, Day, Year) AUG 0 8 2000

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32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24882 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marie 2000 August 1:30 PM Barbara Getzel /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28 1908 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 20 F Director Maryland 218-22-7259 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐ Yes 2☐ No Director Maryland Baltimore 288-4 Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 7232 German Hill Road 21222 U.S. of America Berns 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yes, Give X
Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3. □ Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) NA Food Server Cafeteria 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fin ment of Health and Mental H ant: if them 27 is marked off Jury or other traumatic even Be Godfred Goeb Elizabeth Sedelmyer 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 102 Vegas Drive Hanover, Pa.

20b. Place of Disposition (Name of cemetery, cremetory or other place)

August Roesmarie Pieper (Daughter 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 11 Baltimore, Maryland Baltimore National 21. Signature of uneral Service Cice 22. Neme end Address of Fecility W. Dabrowski-Chojnacki F.H.'s P.A. ication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, no pose on each line. 23a Part Finter the disease, or comp shock, or heart failure. List only o Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel DISEASE disease or condition resulting in death) Examiner Examiner ERTEMSION or Attending Physician: The law requires that the deeth certificate be executed the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): for use signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificata funeral director, 25. Wes case referred to medical examiner? 26. Piace of Deeth (Check only one) Other: 4♥ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Naturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 1 CCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifie completely (Check only one) 945 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Julle August 8,2000 3 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

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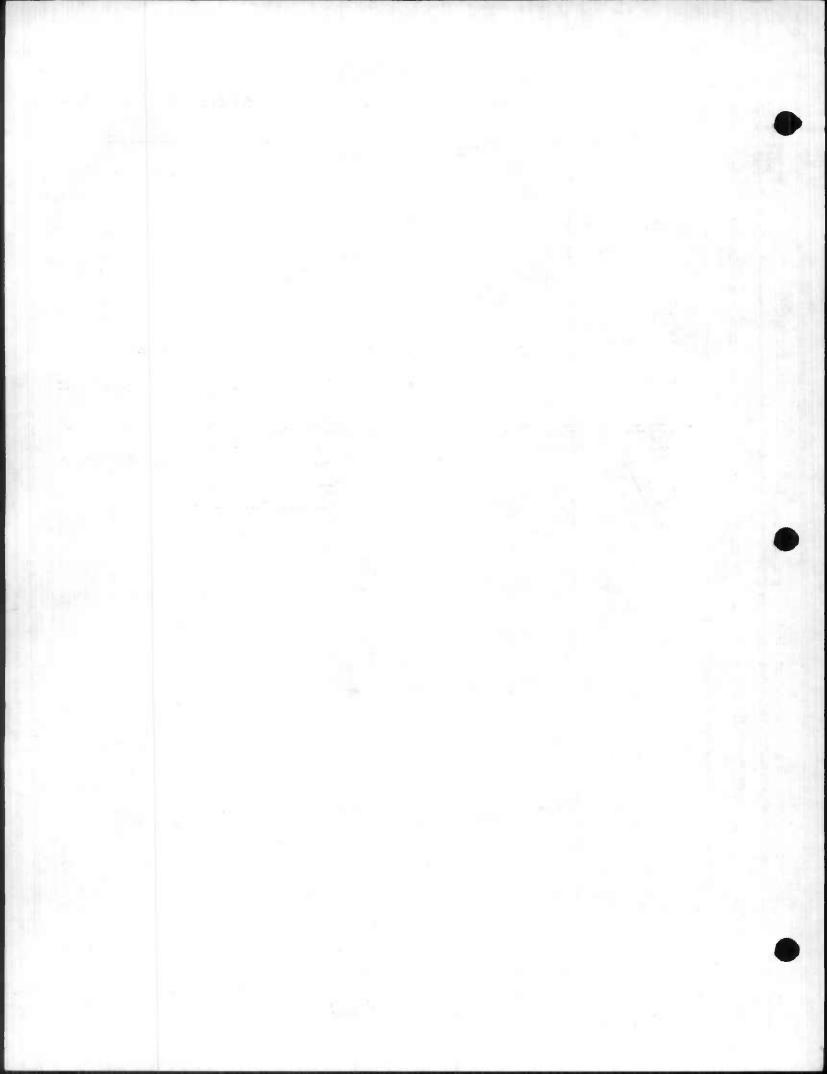
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24883 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month 12:10A.M Charles J. Giordano Angust 2000 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE ANNE HEUNDEL ARUNDEL GLEN HOSPITAL If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1₽M 2□ F Months Days Hours 50 212.54.7647 Aug. 25, 1949 Maryland Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U . S . A . 14. Race - Amaricen Indian, 336 Trois Court 21108 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, GiveA Yaar or Datas: Was Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, etc. 1√2 Nevar Married 2 Married 1□ Yes XXNo Specify Specify: White 3 Widowed 4 Divorced 15. Decedant's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Fruit & Produce Mars Supermarket 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Vincent Giordano Rosalie Serio 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 50 Dorothy St. Port Jefferson Station, NY 20b. Place of Disposition (Nama of carmatery, cremetory or other place) Date 20c. Location - City or Town, Stata Ann Fuhr/Sister 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) Chesapeake Crematory 8/4 Beltsville, MD 22. Nama and Address of Facility Gary L. Kaufman Funeral Home 21. Signatura of Funeral Sarvice License 100 eters 7250 Washington Blvd. Elkridge, MD 21075 Intair the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, or haart failure. List only one cause on each line. Approximete Interval Between Onset and Death immediata Causa (Final disaasa or condition resulting in daath) CIRRHOSIS Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disaase or Injury thet initiated evants rasulting in daath) Last Due to for as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of cause of death? 2 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicel axaminar? 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Daath 28a. Data of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide

Examiner physicien s the burial Box 68760, P.O. Records, Sign P Division of Vital or Attending death.

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State Registrar

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29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the ceuse(s) and mannar as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

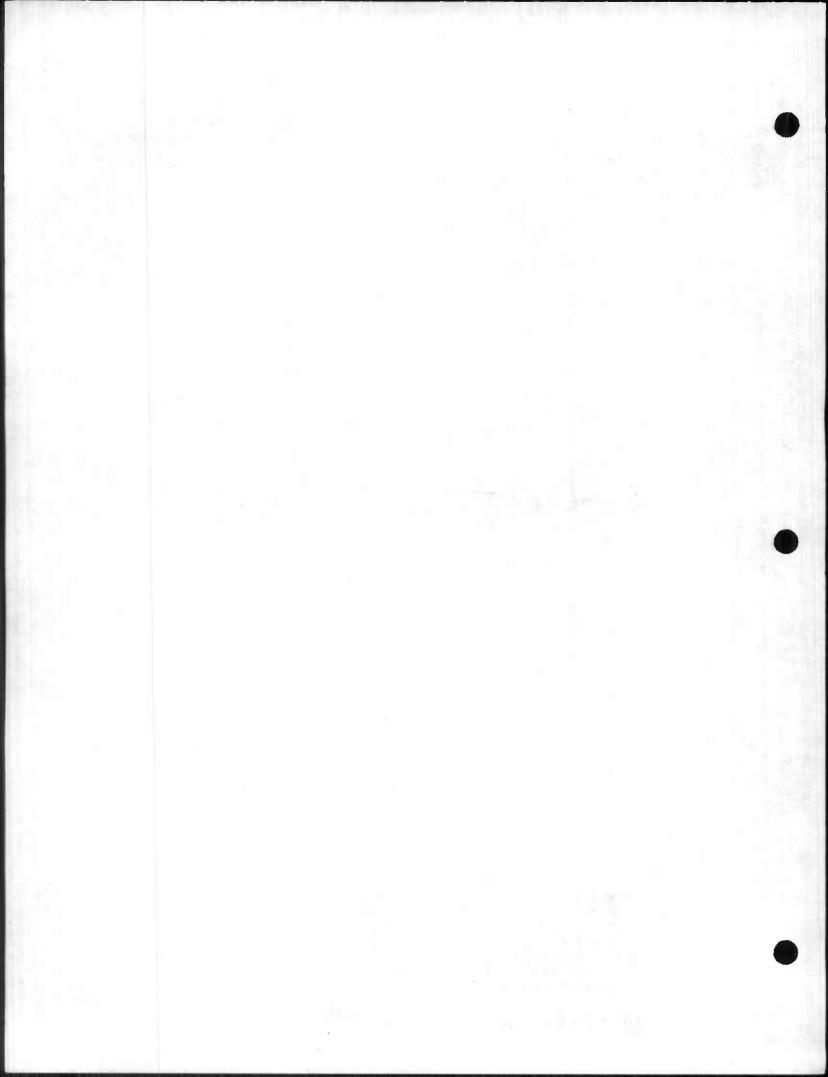
29d. Data signed (Month, Day, Year) 2000

29. Nama and address of person who complated ceusa of death (Item 23a) (Type, Print) NOKEN

32. Registrar's Signature Done Busne in

	Decedent's Name (First, Middle, La	ist)		Certifica	ite of	Death	2. Data of De		3. Tima of Death		
Physician	Robert C.	Gosnell					August	6, 200	5:50pm		
/Medical Examiner	4e Facility Nama (If not institution, give	va street and number)				4b. City, Town, or					
	VAMHCS Fort Ho	ward Divis	ion			Fort Ho		Balti	more		
Funeral Director	5. Social Security Number 213347912. 6. Sex 7. Aga (In yrs. last birthdey) Mo					If Under 24 Hrs Hours Min	. (Month, D	24, 1939	9. Birthplace (Stata or Foral Country) Balto., MI		
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pun il	19a. Informant's Name/Ralationship					and Number or R			414		
m 27 her t	Hope Jackman	Daughter		3 W. Disposition (A		Street			Maryland City or Town, Stata		
of all p	20a. Mathod of Disposition 1 ☐ Burial 2 🕱 Cramation 3 ☐	Ramoval from Stata	y, cramatory o	r other pla		Data 0 / 4 0 / 4					
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nysician	23a. Part1. Entar tha ofsease, or com shock, or haert failura. List only	plication that causad ona cause on each lir	tha daath. Do r ia.	not antar tha m	oda of dyi	ng, such as cardia	c or raspiratory	arrast,	Approximata Intarval Batween Onset and Death		
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ician end burial-transit	Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaasa or injury	c	Dua to (or es e d	consequanca o	1):						
the the	that initiated events rasulting in death) Last	d	Due to (or es a c	onsequence of	():						
igned by the attending be detached for use as by Physician/Me							1				
by the lached	Part II. Other significant conditions	contributing to death bu	it not rasulting Ir	tha undarlying	g causa gr	van in Part I.		Yee 2 No	ntributs to the cause of deal		
o detr								2010	Trobably 400 onkin		
should should							24a. Wa	s an autopsy omed?	24b. Wara autopsy finding available prior to complation of causa of death?		
page Com						•	10	Yas 2 No	1 ☐ Yas 2 ☐ No		
certificate has the string of the complete of	25. Was casa rafarred to medicat					26. Placa of De	ath (Chack only	ona)			
	axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1/2 Inpatia	nt 2 ER/Ou	tpatient 3	DOA Ot	her: 4 Nursing	Homa 5□ Ras	idenca 6 Oth	ar (Specify)		
	27. Mannar of Death 1 ⊠Natural 5 □ Panding	28a. Data of Injui (Month, Da)	y Year) 28b. 1	ima of njury	28c. Inju Wo	ry et ork?	28d. Dascribe	how injury occurr	red		
r death. sctor: After by the fune ification	2 ☐ Accidant invastigation			М	1]Yas 2□No					
irect irect n by	3 Suicide 6 Could not be data mined	28a. Place of Inju- building, ato	iry - At homa, fa :. (Specify)	rm, siraat, fact	ory, office		28f. Location City or To	(Street and Numb own, Stata)	er or Rural Route Number,		
9 9	Ö										
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within 24 hours af To the Funeral Di completely filled in Medical Cel	(Check only 2 Medical Example 1997)	and mannar sta	ted.	2	9c. Lican	sa number		29d. Data signed	d (Month, Day, Year)		
n 24 hou he Fune pletely iii edical	(Check only 2 Medical Examone)	and mannar sta	ted.	2	29c. Licans	sa number		0			
Within 24 hours of To the Funeral D completely filled i	(Check only 2 Medical Examone)	and mannar sta		1	9c. Lican:	739		0	6, 2000		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** MARIE GOVER AUGUST 2000 12:20 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Baltimore Towson H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Nov. 25 1917 If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. Maryland 82 **Director** 219-34-1782 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Baltimore Cockeysville MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be USA 21030 20 St. Elmo Ct., Apt. #102 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 "natural", or White 1 ☐ Yes 2 No Specify: À 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within reth end Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Own Home n/a Homemaker 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martha R. Young Joseph E. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Health or tem 27 la 310 Lord Byron Ln., #T2, Cockeysville, MD 21030 Virgie Beall/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/5°00 Pages 1 permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from Stete Dulaney Valley Memorial Gardens Timonium, MD 21093 of Of uperal Se 22. Name and Address of Fecility Lemmon Funeral Home owell 1 emmon 10 W. Padonia Rd., Timonium, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SMALL BOWEL INFARCTION, TOTAL **Examiner** Due to (or as a consequence of) Physician/Medical Examiner HYPERTENSIVE ARTERIOSCLEROTIC ettending physiclen and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 68760 CARDIOVASCULAR DISEASE thet initiated events resulting in death) Last Due to (or as e consequence of): Box DIABETES MELLITUS signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 20 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier end manner steted. 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 24710 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. REAL, ARMANDO 7601 M.D. OSLER DRIVE TOWSON. MARYLAND 21204

DHMH 16 Rev 6/95

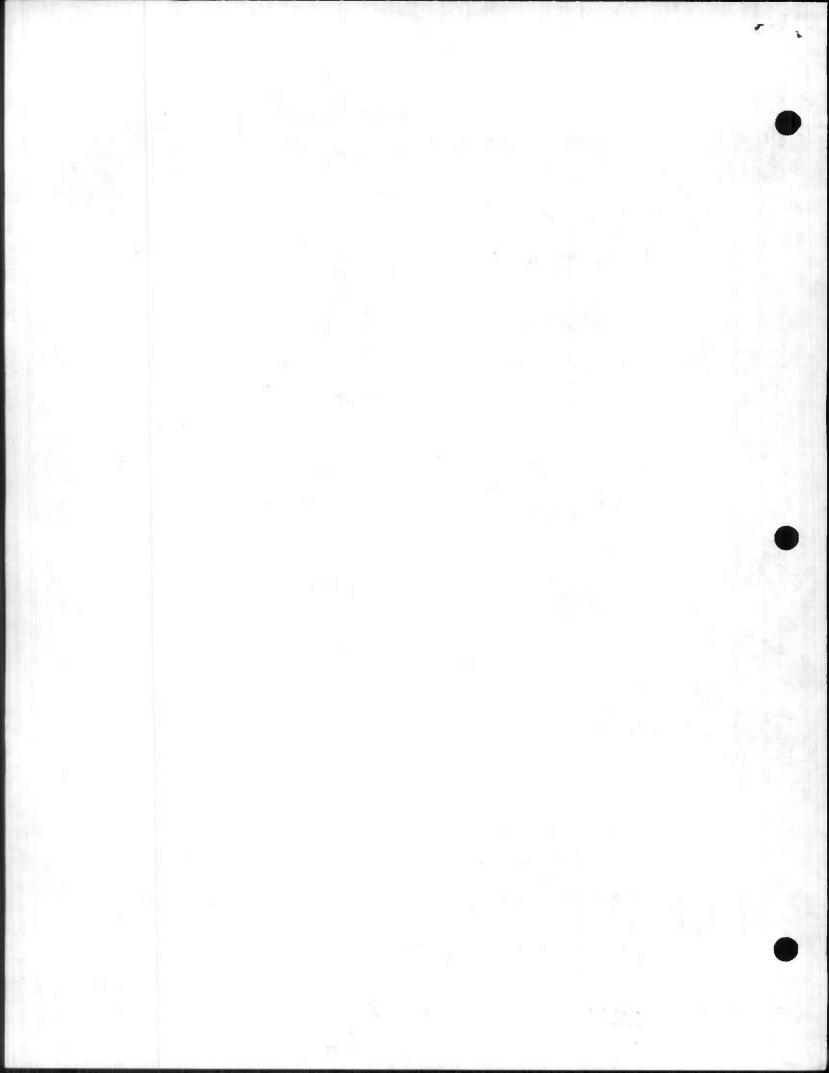
State

Registrar

31. Date filed (Month, Day, Year)

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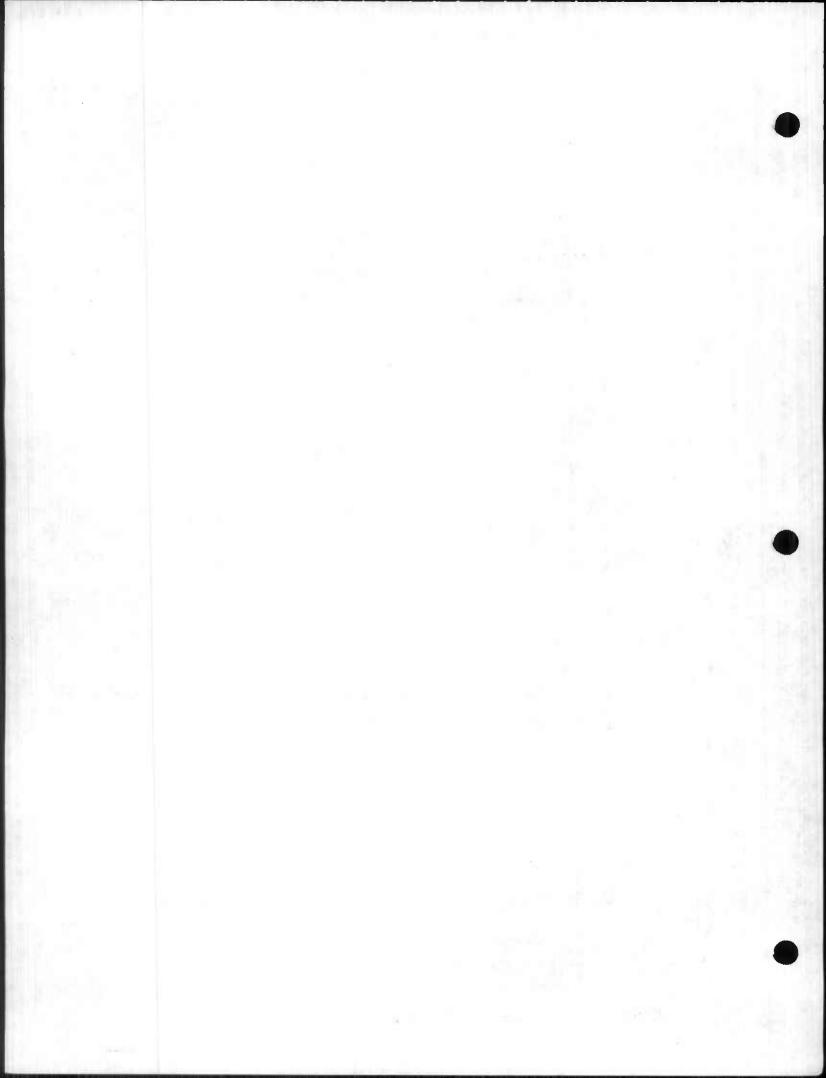
32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death	F	Reg. No.		- 700	, 0
A Control	1. Decedent's Name (First, Middle, Las	(1)				2. Dete of Dee	-	Vaar	3. Time of	Death
Physician /Medical	VINCENT KENNE	TH GRANTI	AND			AUGUS	т 03, 20	OOO	2245	P.M.
Examiner	4e Facility Neme (ff not institution, give	street end number)			4b. City, Town,	or Location of Deeth	4c. County	of Deeth		
	ST. AGNES HOSPITA	L			BALTIM	DRE	N	I/A		
Funeral Director	5. Sociel Security Number 6. Sc 213–14–4664	9x 7. Age (In y	rs. fest birthdey) Yrs.	If Under 1 Yeer Months Deys	Hours M	lrs. 8. Dete of Birth (Month, De) July 22	r. Year)		lace (State o try) vland	r Foreign
2 .	Usuel Residence of Decedent 10a, State 10b, County	100	City, Town or Lo	anting						A. A. Sandka
the Maryla 28s-f shon notified at	14.7		Baltimo				300		Od. Inside Cl	
5 58 0	10e. Street and Number 313 E. Hamburg	Street		10f. Zip Code 2123	0	7	10g. Citizan of W US		try?	
020 us after death v ef, or thems 23s Examiner must by Funeral		12. Wes Decedent Ever in Armed Forces? 1 TYPES 2 No If Yes, Give Yeer or Detes:		Wes Decedent of I If Yes, specify Cub 1☐ Yas 2☐No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		- Americ k, White, a	atc.	
22 ho	15. Decedent's Ed (Specify only highest grad		16e. Dece	dent's Usuel Occu	pation	working	16b. Kind of Bu	siness/Inc	lustry	
Maryland 21215-0020 d 2 should be filed within 72 hours at m and Mental Hygiene. The membed other than "natural", or traumatic event, the Medical Exam To Be Completed by 1	Elemantary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		Chipper	& Co	olker	Co.
be file d office went,	17. Fether's Neme (First, Middle, Last)				18. Mother's I	Neme (First, Middle,	Maiden Sumem	e)		
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and short	19e. Informent's Name/Ralationship (7		19b. Maili	ng Addrass (Stree	end Number or	Rural Route Numbe	r, City or Town,	Stete, Zip	Code)	
- 5384	Grace Grantland	(Wife)	313	E. Hambu	irg Stre	et, Balti	more, M	d. 21	1230	
Saltimore, emit. Pages 1:s bepartment of He mportant; if item ny injury or other size.	20e. Method of Disposition 1 Description 5 Other (Secrit	Removel from State	cemetery, cre	osition (Neme of matory or other pla		Dete 8/07/00	20c. Location -			
altir partme ortan injur	4 □ Donation 5 □ Other (Specify 21. Signeture of Funeral Service Licen			2. Name end Addre		10/0//00	Gren B	urnie	e, Ma.	
CO COMPANY	Miotina d.	Autton		McCully-	-Polynia Fort ave	k Funeral	re. Md.		30	
Physician	23e. Pert1. Enter the disease, or comp shock, or heart failure. List only	blicetions thet caused tha done causa on each lina.	eeth. Do not an	tar tha mode of dy	ng, such es cero	diec or respiretory er	rest,		Approximate Interval Bate Onset and I	waan
/Medical	Immediate Couse (Finel disease or condition	. 5	ups i	S					10 ho	urs
	resulting in death)	1	o (or es a conse		2	15.17	100			
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6876(ficate be physicie ss the bur	Cause (Disaese or injury that initieted events resulting In death) Lest	c. Due to	(or es e consec	quenca of):						
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cords, requires should be should be						24a. Wes	en autopsy med?	ev:	ara autopsy f ailebla prior t mpletion of c daeth?	to
The lay ate hes page 2						101	as 200		Yes 2	rate.
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	axaminer?	Hospitel: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA Ot	her:	g Homa 5 🗆 Resid		ne /Canais	vd.	
The state of	27. Menner of Deeth 1 Phaturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year		f 28c. Inju		-	now injury occurr		77	
W = 0 0 = 0	3 Suicide 6 Could not be datarmined	28a. Place of Injury - A building, atc. (Spe	t home, farm, sl	reet, factory, offica		28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rure	I Route Num	ber,
DIVI To the Hospital or At Within 24 hours effer of completely filled in by Medical Certiff	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	reician: To the best of my liner: On the basis of exam and mannar stated.	knowledga, daat inetion and/or in	h occurred at tha to vestigation, in my	ima, data and plo opinion, daath o	ace, and dua to tha courrad et tha time,	ceuse(s) and me data end place, a	enner as si and dua to	tated tha ceuse(s	5)
Withir To the comp	29b. Signeture and title of certifier	110		29c. Lican			29d. Data signed			T. P.
	> / Whix	Xan	MIS	Do	00533	12	ausus	+4	1200	0
no, p	30. Name and address of person who of Michelle Hengsel	completed ceusa of deeth (I	tem 23a) (Type, ten aven	Print) bi-	Himor	e, mo				
State Registrar	31. Dete filed (Month, Dey, Year) AUG 0 8 2000	Se 32. Registrer's Sig		a Val		17,10				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Rose Betty Greenberg August 2000 7:30AM /Medical 4e. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Maryland Masonic Homes Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sax 1□ M 20 F 7. Aga (In yrs. last birthday) Birthpleca (Steta or Foreign Country) **Funeral** Yrs. Director 213-12-0027 90 06/25/1910 Russia Usual Residence of Decedent the Meryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "naturet", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be indiffed at 1 ☐ Yes 2 No Director MD BALTIMORE COCKEYSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 300 INTERNATIONAL CIRCLE #105 21030 U.S.A. permit. Pages 1 end 2 should be filed within 72 hours efter death a Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a and injury or other traumatic event, the Medical Examiner investions. Funeral 12. Was Decedant Ever in U,S Armed Forces? 14. Race - American Indian, Bleck, Whita, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: WHITE by 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALES DEPARTMENT STORES 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be **GOLDBERG** (UNKNOWN) HENRY FREDA 0 19a. Informent's Neme/Reletionship (Type, Pnint) 19b. Melling Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code) 2307 VELVET VALLEY WAY - OWINGS MILLS, MD 21117 FREDERICK I. GREENBERG / SON 20b. Pleca of Disposition (Name of cemetery, crametory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramovel from Stata MIKRO KODESH BETH ISRAEL 8/7/00 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ews that only one plans on each line. tntervel Between Onset end Deeth **Physiclan** Diffuse attersceloter Disease /Medical tmmediete Ceuse (Final Glees disease or condition resulting in deeth) Examiner Advenued Ag physician end s the buriel-transit thet the death certificete be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initieted events rasulting in deeth) Lest P.O. Box 68760, Physician/Medicai Dua to (or es a consequenca of): ettending p signed by the e Pert ft. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Demertin Records, þ 24a. Wes en autopsy performed? 24b. Were eutopsy findings sveilable prior to complation of causa of desth? Completed peed page 2 s certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Was case referred to medical Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 10 27. Mennar of Deeth 28e. Dete of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicida 28e. Pleca of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, dete end pisca, end due to the causa(s) and menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to tha cause(s) and mannar stated. 29a, Certifier 29b. Signetura and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) , Ms. 30. Neme and sddress of person who completed cause of deeth (Item 23e) (Type, Print) ROBERT LIBERTO, MD. 3508 BANK St. BALTO, MD. dlddy

State

Registrar

31. Data filed (Month, Dey, Year)

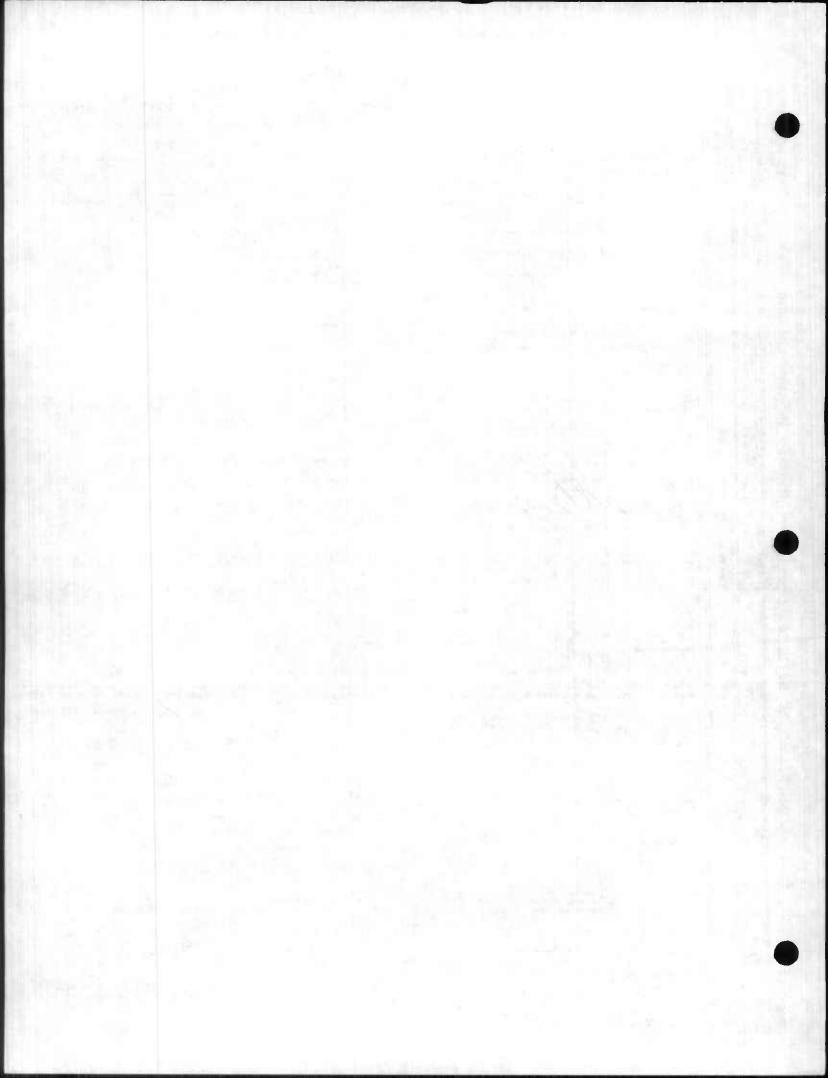
AUG 0 8 2000

32. Registrar's Signeture

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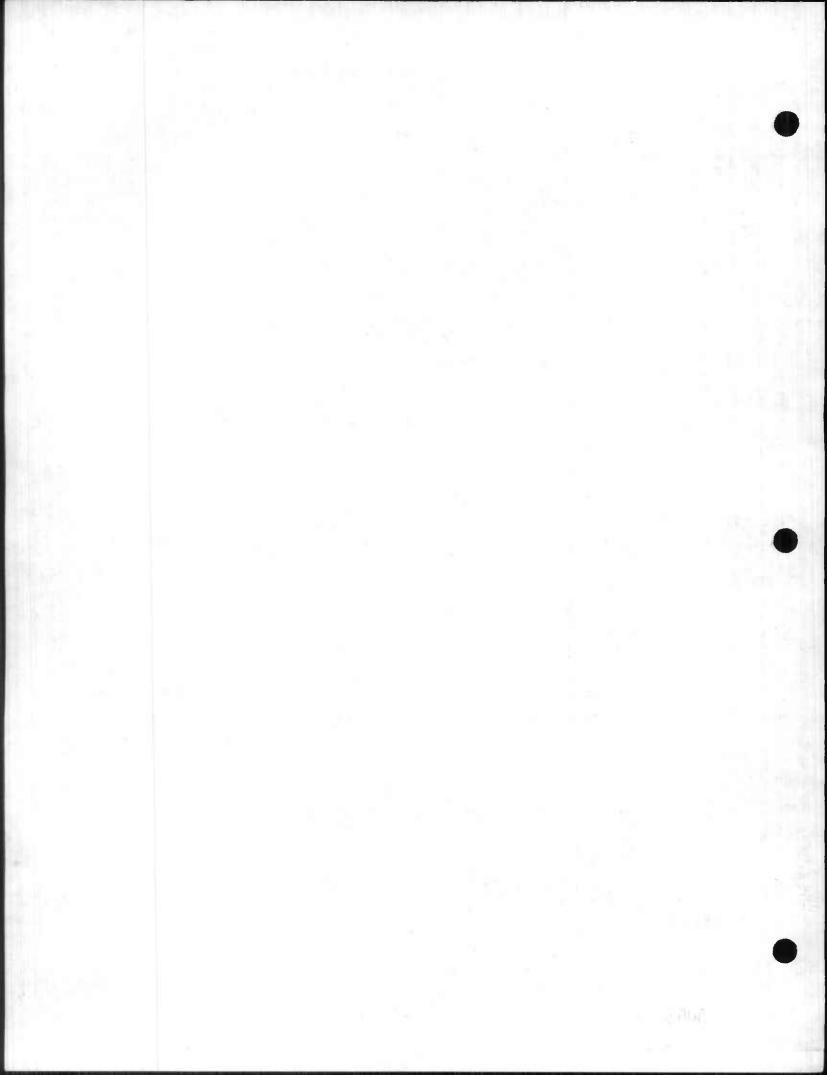
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 24888

							,	Cei	tificat	e of	Death		Re	g. No.		. 4000
			1. Decedent'a Name (First, Middle, La	st)								Date of Death	E	Year	3. Time of Death
	Physicia /Medic			SHIRLE	Z				GREE	NBE	RG			2000		9:45 PM
	Examin		4a Facility Nama (If n	ot Institution, giv	a street and num	ber)	201				4b. City, Town	, or Locatio	on of Death	4c. County	of Death	
	1		7238 PA		HTS AVEN	UE_	#A				BALTI			N/A		
	Funeral Director		5. Social Security Num 111-03-06	58	ex □ M 2(X) F	7. Age	(In yrs. last bii 95	rthday) Yrs.	If Unda Months	Days		Min.	Date of Birth Month, Day, N.5,19		9. Birthp Coun	lace (State or Foreign try) RUSSIA
	pur *		Usual Residence of De 10a. State 1	ecedent 0b. County		1	IOc. City, Tow	m or Lo	cation	-					11	0d. Inside City Limits
	e Marylan	ctor	MD	N/A					IMORE			3.48				1 Yes 2 No
46	death with the Maryland rms 23e or 28e-f ehow	al Director	10e. Street and Numb 7238 PAI		HTS AVEN	UE	#A		10f. Zig	Coda	21208		10	U.S.		try?
	within 72 hours after death with the Maryls ene. Than "natural", or thema 23s or 28s-f ehov the Medical Examine mast be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐	_	12. Was Dece Armed For 1 Yes If Yes, Giv Yaar or Da	ces? 2 ₩ No			Vas Dace I Yas, spe I □ Yes		Hispanic Origin ban, Maxican, F Specify:	? (Specify Puarto Rica	Yes or No- n, etc.)		k, Whita,	an Indian, etc. WHITE
2-0		Be Completed	(Specify	5. Decedent's Ed	ducation		18a	Deced (Give	tent's Usu	al Occu	pation	f working	1	6b. Kind of Bu	siness/inc	dustry
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CA	o filed with of Hygiene. other than vent, the N	S	8	and definitely depart	_		S	ALES	SLADY		*** **********************************	Name /Fig	not Adiatello At	CLOT		
Maryland			17. Father's Name (Fit HYMAN)	rst, Middle, Last,			LIFSCH	Tጥ7			ROSE	Name (Fil		laiden <i>Suma</i> m KNOWN)	9)	
2	d 2 should but and Mente	2	19a. Informant's Nam	a/Polationship /	Tumo Print)				a Addres	e (Strac	et and Number of	or Pural Po		-	State 7in	Code
E a	d2: ch ar		KENNETH (•		COURT -					0000)
ē,	if item 27 or other tr		20a. Method of Dispos		10 / 5011		20b. Place o	f Dispo	sition (Na	me of				Oc. Location -		own, Stata
OE .	Peges nent of int or o		1 X urial 2 0			Stata			N CHI		AMUNO	8/7	/00	BALTI	MORE	MD
	permit. Peges 1 a Department of Her Important: If item eny Injury or othe		21. Sefatura di Fune	ral Service of the	2112						ress of Facility	SOL	LEVIN	ISON &	BROS.	, INC.
		4	238 Part 1. Enter the	disease, or com	pications that ca	usad th	ne death. Do	_							LE, N	Approximate Interval Between
	Physician .		238 Part 1. Enter the shock, or heart t	ailure. List only	cause on ea	ich line					S. S. O. Barriero				1	Onset and Death
	/Medical		Immediate Cause (Fir	nal		(ARCI	40 h	JA		05	BR	FAS-	-		10,000
Н	Examiner		resulting in death)		a	D	ue to (or as a	consec	uenca of)			10				10913
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60,	lcian buria	S E	Sequentially list conditions, leading to immicause. Enter Underly Cause (Disease or Injurtat initiated evants	ing	С										i	35566
68760,	a death certificate be assouted the attending physician and thed for use as the burial-transit	edical Examiner	resulting in death) Las	st		Du	ua to (or as a	conseq	uenca of):							
Вох	nding use e	3			d											
m .	death e atte	icla	Part il. Other significa	nt conditions o	ontributing to de	ath but	not resulting i	n the u	nderlying	cause o	iven in Part I.		23b. Did tol	bacco uas co	ntribute to	the cause of death?
0	tha by the	Physician/N			ROIDT								1 □ Ye	· V	3 Pro	
S,	on de de	by F	14 51 00	1 117	2010	>	/]					-				
Division of Vital Records, P.O.	The law requires that the death centate these been signed by the attending page 2 should be detached for use.	Completed by											24a. Was ar perform		av	era autopsy findings ailable prior to mplation of causa death?
Re	a he ta	E											1□ Ya	s ZONO	1[]Yas 2□ No
a	Iffical tor, p	Bec	25. Was case referred	I to medical							26. Place of	f Death (C/	heck only one			
>	ysich is cer direc	ToB	axaminar?		Hospital:	patient	2 ER/O	utpatien	1 3 D	OA O	thar-			nca 6 □Oth	er (Specil	(v)
o uc	for Attending Physician: The taw siter dealer this certificata has I Director: After this certificata has I In by the funeral director, page 2:	Certification:		5 Pending		Injury		Time of Injury		28c. inj			Describe ho	w injury occur	red	
Sic	deeth deeth deeth deeth tor: /	Cat	2 Accident 3 Suicide	investigation 6 Could not b		of Inius	. At home for	arm etc	M oot factor		Yes 2 No		Location (Str	reet and Numb	er or Rure	al Route Number,
<u>></u>	or A after Direct	enti	4 ☐ Homicide	determined	buildir	g, etc.	y - At home, fa (Specify)	ariti, ətt	oot, iactor	y, omce		201.	City or Town	, State)	01 01 7 1010	, riodio ridinos,
	To the Hospital within 24 hours (To the Funeral completely filled	edical C	29a. Certifier 1 (Check only 2[©Certifying Ph ☐ Medical Exam	ysician: To the niner: On the be	sis of e	xamination ar	e, death	occurred restigation	at the	time, date and popinion, death	place, and occurred s	due to the ca t the time, da	use(s) and ma ite and place,	inner as s and due to	tated. o the cause(s)
	To the within 7 To the comple	Me	29b. Signature and III)	e of certifier	una mam	J. 51816			29	c. Licar	nse number		29	d. Date signe	d (Month,	Day, Year)
	20		> /IX	M					9	119	1317			877/0	0	
	0	8	20. Name and address	of person who	completed cause	of dea	th (Item 23e)	(Type	Print)	/				110		
	M	0	BORT 3 K	ERRE	eno	182	8 G-6	155×	(125	c R	> BA	CTI	Mar	EIF	0	21208
	Stat		31. Date filed (Month, AUG 0 8 2	Day, Year)	he 32. Re	gistrar	s Signatura	In	de		(
	Registra	ar I	HUU U O L	000		/	1	To	40%	5						



State of Maryland / Department of Health and Mental Hygiene 00 24889

		Certificate of Death	Reg. No.							
DI	Decedent's Neme (First, Middle, Last)	/ /.	2. Dete of Death Month Day Year	3. Time of Deeth						
Physician /Medical	James Kenneth H	artins	August 4, 2000	3:55 F						
Examiner	4a Facility Name (If not institution, give street end number) +41/5/09 Fehrer HOSy	46. City, Town, or Falky	on Harto	rd						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Mass 215-03-0996 1 ☑ M 2□ F 8	6 Yrs. Hours Deys Hours Min.		plece (Stete or Fore ntry) land						
2 2	Usuel Residence of Decedent 10a. Sfate 10b. County 10c. City, T		10d. Inside City Lin							
28a-f shown notified at	MD Harford Bel			1□ Yes 2⊠						
23a or 28a-fa unt be notified al Director	10e. Sfreef and Number 334 E. Crocker St.	101. Zip Code 21014	10g. Citizen of Whet Cou USA	10g. Citizen of Whet Country? USA						
of, or frems by Funer	11. Maritel Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Yeer or Detes:	Nas Decedent of Hispenic Origin? (S If Yes, specify Cuben, Mexican, Puer □ Yes 2⊠ No Specify:	Specify Yes or No- to Rican, etc.) 14. Raca - Ameri Black, White, Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)								
omp		Warehouse supervisor								
M of H	17. Father's Neme (First, Middle, Last) Charles Harkins		me (First, Middle, Maiden Sumame) 1 Bailey							
27 is mark traum	19e. Informent's Neme/Relationship (Type, Print) Carole Brooks	19b. Mailing Address (Street and Number or R 334 E. Crocker St., E		p Code)						
net of Her	1 Buriel 2 Cremation 3 Removel from Stete	a of Disposition (Name of etery, cremetory or other piece) s Funeral Chapel-Bel Air	Aug 6	20c. Location - City or Town, State Forest Hill, MD						
hysician /Medical examiner Examiner	b .	c Obstructions a consequence of):		Approximate Interval Betweet Onset end Deat						
ing physicia e es the bu	Cause (Disease or injury that initiated events resulting in death) Lest Due fo (or as e consequence of):									
d by the ettend statched for us	Part II. Other significant conditions contributing to death but not resulting	23b. Did tobacco uas contributs	to the causs of de							
900	Congestive Hea	ert tailure	1 Yss 2 No 3 Pro	obably 4 Wink						
s been s 2 should pieted			performed?	Vere autopsy findir vellable prior to ompletion of cause f death?						
pege Com			1 □ Yes 2 ☑ No 1	☐Yes 2☐No						
s certificate director, per	25. Wes case referred to medical examiner?		ath (Check only one)							
fler this uneral di on: To		/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residenca 6 Other (Spec 28d. Describe how injury occurred	ify)						
0 0 - 0	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home building, etc. (Specify)	o, ferm, street, factory, office	281. Location (Street end Number or Ru City or Town, State)	ral Route Number,						
within 2 hours after the funeral Direct completely filled in by Medical Certiff	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examinetion and manner stated.	dge, death occurred at the time, date and plec end/or investigation, in my opinion, death occ	e, and due to the cause(s) and manner as urred at the time, date and place, and due	stated. to the cause(s)						
15 E X	29b. Signature and title of caddler	29c. License number	29d. Date signed (Month	, Dey, Year)						
N With	11 -1 line to 111	11-24.		00						
N.J.	30. Neme and address of person who completed cause of deeth (Item 23	38 (Type, Print) 104 plus	when Del Ma	1 A 10 1						



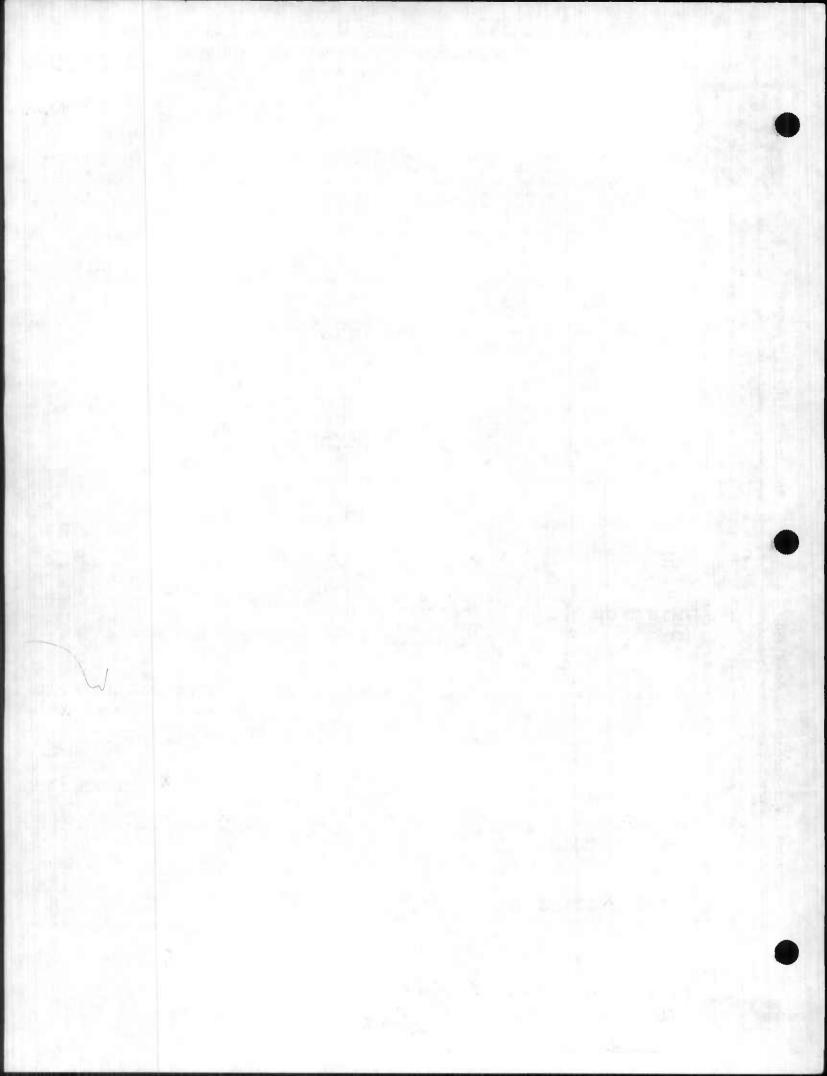
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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24890

					OCILII	icate or	Doutin		Heg. No.		
Physician /Medical	radit to za	ne (First, Middle, La nna Hoffm						2. Data of D Month Augus	eath t 6, 2000	Year	3. Time of Death 8:40pm
Examiner	4a Facility Nama (<i>If not Institution, giv</i> Ither Blv	d., Trevo	r 3420			4b. City, Town, or Parkvill		th 4c. County Balti		
Funeral Director	5. Social Security N	3039	Gax 7. A 1□ M 2⊠ F	ga (In yrs. last bii 8 4	M	Under 1 Yaar lonths Deys	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)	9. Birthi Cour Mary.	olaca (Steta or Foreign ntry) land
70	Usual Rasidanca o										
of an	10a. Stata	10b. County		10c. City, Tow	m or Locati	ion				1	10d. Inside City Limits
Man A	MD	Baltimo	ore	Parkv	ille						1 ☐ Yas 2 ☒ No
off the Ma or 25a-t s be notified	10e. Street and Nu	mber				10f. Zip Coda			10g. Citizen of V	Vhat Coul	ntry?
4 62 m m	8810 Wal		d. , Trevo	or 3420		21234			U.S.A.		
ar dass Name ner me	11. Marital Status		12. Was Deceden Armed Forcas	Ever in U,S.	13. Was	Decedant of I	Hispanic Origin? (Specify Yes or N rto Rican, atc.)	o- 14. Rac	a - Amarick, Whita,	can Indian,
		ried 2 Merried	1 Yas 2			Yas 2⊠ No			Specify		
21215-0020 d within 72 hours at gene. The Medical Exam correleted by		4 Divorced	Yaar or Datas:							ite	
21215-0 ed within 72 ho eg within 72 ho er than "netur er than "netur t, the Medical	(Sne	15. Decedent's E		16a	. Decedent	's Usual Occup	pation during most of we	orkina	16b. Kind of Bu	usiness/In	dustry
12 a and 10	Elementary/Seco		College (1-4or	5+)	lifa. DO	NOT use ratire	during most of wo		Home		
Paris a	1:			H	omema	ker					
D State		(First, Middle, Last)				18. Mothar's Na	ma (First, Middl	a, Maidan Sumam	a)	
ylanc ylanc Mental H Mental H	William	Herman G	Grabau, Sr				Minnie	Rosella	Bowen		
V WANTER P		lame/Ralationship (Time Print)	10	h Mailing A	Addrass (Straa	t and Number or F	Rural Routa Num	ber, City or Town,	Stata 7ii	Code)
Maryland 42 should be file th and Mental Hy 7 is marked othe treumatic event			n - Daugh		_				kvillle		
- 5975									20c. Location -	-	
TOT HIGH WING	20a. Mathod of Dis		Removal from State		ry, cramate	ory or other pla		Aug 10			
aitimore, hall partment of Health partment of Health partment of Health partment if them 27 y Injury or other base.		5 Other (Special		Garder	ns of H	Faith Cem	netery	Aug 10 2000	Rosedal	.e, M	ID
五 一	21. Signeture of Fu	uperal Service Lice	nsee	11		ama and Addra		1			
W FORTER	1 × Ko	18/19	Pall	2008	E7	vans Fu 800 Har	neral Ch ford Rd.	apel Parkv:	ille, MD		
	23a Part 1. Entar I	tha disaasa, or com	plications that cause ona causa on aach	d tha deeth. Do	not entar t	ha moda of dyi	ng, such es cardia	ac or raspiratory	arrast,	1	Approximata
l Physician	shock, or has	art failura. List only	ona causa on aach	lina.						- 1	Interval Between Onset and Daath
/Medical	Immedieta Ceusa	(Final				a.	A	-		i	-
Examiner	diseesa or condition	on	a	and	oc	as	nese				5
MESTATES .			_	Due to (or es a	consequer						1
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omecuted in and intransit	Sequantially list co	onditions,		Due to (or as a	consequar	nca of):					
60, be executed burishes and Exac	Lause. Elliel Ollu	ertying		tuno	000	mai'	em				
68760, ficate be a physician as the buris	that initiated evant	s Lact	C	Dua to (on as a	consequen	ica of):				1	
		Lasi								1	
OX osetti use a	12.00		d							-	
								1			
0 8 44 8	Part II. Other signi	ficant conditions of	contributing to death	but not rasulting i	in tha unda	riying cause gi	ven in Part I.	23b. Di	d tobacco use co	ntributa t	to the causa of death?
P.O. B. that the death detached for Physicia								10	Yes 2 No	3 Pro	bably 400 Unknown
Vital Records, steam The law requires to certificate has been signal rector, page 2 should be be See Completed by								24a. Wa	s an autopsy formed?	81	ere autopsy findings vailable prior to
on we select					-					of	ompletion of causa f deeth?
Il Rein									Yes 2 No		□Vaa a□Na
E			1								☐ Yas 2☐ No
Vital Factor, Page Co. PBe Co.		rred to medical	Hospitel:			10	har:	eeth (Check only			
Physic Physics of the standard of To		.	1 L Inpat		utpatient	3LI DOA	4 Li Nursing	-	sidence 6 Oth		ify)
The Page	27. Mennar of Deal	th 5 ☐ Pending	28a. Dete of In	ury ay Year) 28b.	Tima of Injury	28c. Inju	ry at X	28d. Dascrib	how injury occur	red	
oi age	2 Accident	investigetio	n			M 10	Yas 2□No	11.74			
Divisio	3 ☐ Suicida	6 Could not be detarmined	289. Place of It	jury - At home, fa	arm, streat	, factory, offica		28f. Location	(Street and Numb own, Stata)	per or Rur	ral Routa Number,
D settle	4 Homicida	X	bullaing, e	ic. (Specify)				City of 1	own, clara,		
Hospital or st Hours att. Fureral Dir tay filled in lical Cert			nysician: To the bes	of my knowledge	a death or	curred at the t	ima deta and plac	e, and due to th	e causa(s) and ma	annar es	stated.
Fundamental	(Check only one)		miner: On the basis	of axamination ar							
To the To the comple	the second second second second	t this of continue	and marrial s			29c Licen	sa number		29d. Data signe	d (Month	Day Year)
PAPE .	29b. Signature and falla of certifier 29d. Data:										, - ey, - war/
.0 -	1 /	kne	V Can	1 11	-1)	D.	3728		8/7/	00	
10.5.	30. Nama and add	ress of person who	complated causa of	daath (Itam 23e)	(Type, Pri	nt)			11		
W	56011	InRag.	a Rhid -	5 11.	noce	me					
State	31. Data filed (Mon	nth, Dey, Year)	32. Regis	rar's Signatura	ue	1111					
State	ALIGO		house	4	/	. /					

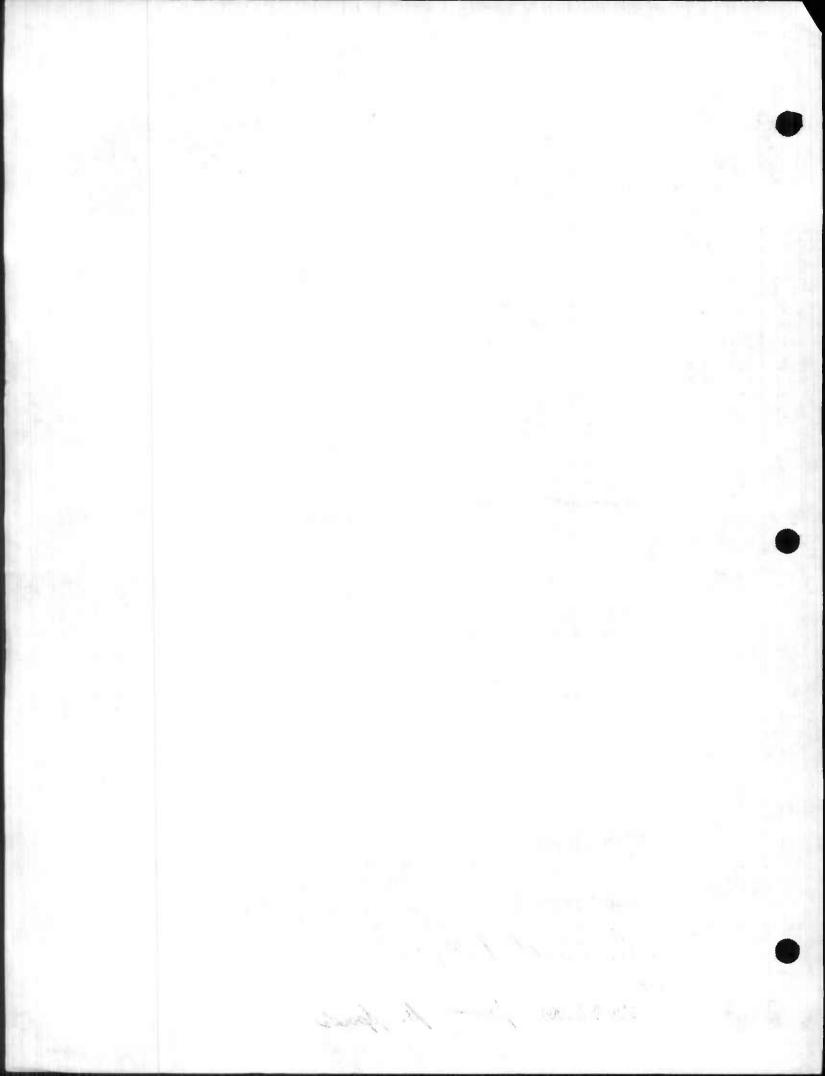


State of Maryland / Department of Health and Mental Hygiene 00 24,891

W	AMEND	TTEMS: #23	PART I,	21, 28	A-F. PE	R MEOCE	niicai	e or l	Jeatn		3	Reg. No.						
	6 1	1. Decedent's Nem	e (First, Middle, La	st)							2. Dete of Dec Month	eth Dey	Yeer	3. Time o	of Death			
	Physiciar /Medica	KRI	ENDA LY	INN H	OLTZ						AUGUST		2000	000 09:20 A.M				
	Examine	4a Facility Name (/			iumber)			4	b. City, To	wn, or L	ocation of Deeth	4c. County	4c. County of Deeth					
40		1338 P	ONTIAC AV	VENUE					BAL	TIM		N/	'A					
	Funeral	5. Social Security N			7. Age (In y	rs. last birthday,	If Under Months		If Under Hours	24 Hrs. Min.	8. Dete of Birt			plece (State	or Foreign			
Ш	Director	212-82-79	44	I		41 Yrs.	MOINTS	Deys	Hours	IVIII I.	May 17	,1959	MARY	LAND				
	2	Usuel Residence of																
	shyta dat	10a. Stete	10b. County		100.	City, Town or L	ocation											
	No Maria	MD.	N,	/A		BALTII	- 1								20140			
	or 28s-f s	10e. Street and Nur					10f. Zip					10g. Citizen of	What Cour	ntry?				
	23 Mark		ONTIAC AV	,				212				U.S						
	after death with the Maryla or hams 23s or 28s-f shor crines must be notified at	11. Marital Status		Armed I		1 U,S. 13.	Wes Dece	dent of Horify Cuba	ispanic Ori in, Mexican	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)							
20	72 hours after natural, or it Scal Examin		ied 2 Married	1 Yes, C	Sive No		1 Yes	2 💢 No	Specify:			Specif	у:т					
8	Men Men			Yeer or	Detes:	40x P-11	desate Mess	-1 0	**!**			10h Kind of D		American Indian, White, etc. WHITE ness/Industry ate, Zip Code) ARYLAND 21230 ty or Town, Stete RE, MARYLAND MARYLAND 21224 Approximate Interval Between Onset and Death The Probably 41 Unknown 24b. Were autopsy findings aveileble prior to completion of ceuse of death? 10 Yas 2 No				
5	led within 72 ho lygione. her than "meturn it, the Medical	(Spec	15. Decedent's Edify only highest gre	de completed	d)	(Give	dent's Usu kind of wo DO NOT u	nk done o	ation during mosi	t of work	king	100, King of b	usmess/m	dustry				
12	S Paris	Elementery/Seco		College	(1-4or 5+)		TAL TI					DENT	ΛΙ					
9	DEPT.	17. Fether's Name)		DEN	IAL I	LCTIN.		r's Nem	e (First, Middle,							
an	id be til sad oth ic even		D J. BRAD								A CLARK							
2	d Me d Me ment	19e. Informent's Ne				19h Mail	ing Address	(Street				er City or Town	State Zir	Code)				
Maryland 21215-0020	d and and and and and and and and and an	DUELLA BI													1000			
e,	Tan de	20a. Method of Disp		THEK	200	. Plece of Disp	osition (Nai	ne of		-1-	Dete DAL	20c. Location	- City or To	ANU_Z own, Stete	1230			
Baltimore,	ages of it it		Cremetion 3			cemetery, cre				0	r (00	DALTIM	005 1	I B D V I B	ND			
Ē	nitan nitan	21. Signeture of Fu	5 Other (Specif			GARDENS	2. Name ar				5/00	BALIIM	UKE, M	IARYLA	עא			
Ba	Depri	21. digitata di 1 d	ineral de la cide	1300	10	1	LILLY	& Z1	EILER	INC	. FUNER	AL HOME						
		Offic Parts Forest	Bearing .	03	1000		700 S	COL	KLIN	G ST	REET, BA	LTIMORE	, MARY		21224			
45		23a. Part1. Enter the shock, or hee	rt failure. List only	one cause on	eech line.	Beth. Do not en	iter the mod	ie oi dyiii	y, sucri es	Cardiac	or respiratory er	1051,		Interval Be	etween			
	Physician /Medical	Immediate Cause ('Final		0	XYCODON	E TAPTY	OVIC	ארדר או									
	Examiner	disease or condition resulting in deeth)	n	a					ALLON									
		5			Due to	o (or es e conse	quence of):											
	ficete be assected physician and ts the burial-transit			b	Due to	(1					
,	certificate be axecuted ding physician and isa as the burial-transit	Sequentially list colif any, leading to imcause. Enter Under Cause (Disease or	nditions, nmediete		Due to	o (or es e conse	quence or).											
68760,	e be be	Cause (Disease or thet initiated events		C	Due to	(or es e conse	nuence of):											
	g phy as th	resulting to deeth) I	Lest			(0. 00 0 00.00	4-0											
XO	_ 63 6			d						_								
0	igned by the attan be detached for u	Pert It. Other signif	Icant conditions	ontributing to	death but not	resulting in the	underlying	euse giv	en in Part i		23b. Dld	obacco uee co	ontributa t	o the cause	of death?			
P.0	that the ed by th detach										10	Yee 2 No	3 Pro	bably 47	Unknown			
	= 00									_			_					
Records,	been sign should be											en eutopsy rmed?	24b. W	ere autopsy eileble prior	findings to			
S	law requias been 2 should					11-43				-					ceuse			
	0 - 0										1X	(es 2 No	1	Yas 20	□No			
Viita	certificate	25. Was cese refer	red to medical						26. Place	of Dea	th (Check only o	one)		1				
	Physician: this certific ral director,	1 TWAS 2	No	Hospitel: 1	Inpatient 2	ER/Outpatie	nt 3 D	Oth Oth	or.		ome 5 Resi		her (Speci	(y) CCI	ENTE			
10				28e. Det	e of Injury	28b. Time	A lo	28c. Injur Wor	y et		28d. Describe	now injury occu	rred	-361	EIVE			
0	Attending ir death. actor: Afte by the fune	1 Naturet 2 Accident	5 Pending Investigation	Foun	2-00	Fourte	• м		Yes 2 🛚	No	UN	KNOWN						
Division	Arte ecto	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Pte	ce of thiury - A	t home, ferm, s	treet, fector	y, office			28f. Location (Street and Num vn, State) 13	ber or Run	Plante Nu	mber,			
	tal or Attanding P rs after death. al Director: After t led in by the funera			0011	iding, oto. (ope	RE	SIDEN	CE			BALTIMO	RE, MD.	50 10	MITAC	. Avb.			
	in 24 hours in 24 hours he Funera plataly fill	29a. Certifier (Check only	1☐ Certifying Ph												(2)			
	To the Hospital or Attanding Ph Within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral			end me	enner steted.	and and in				0000								
	To with To the Com	29b. Signeture end	of certifier	./	1		29		e number .M.E.			29d. Date sign						
		1,6	ceoder	4	Ker	7) ~~)	0.0	·H.E.			AUGUS	or 03	, 2000	J			
		30. Neme and addre	ess of person who	completed ca	use of deeth/(I	23e) (Type			130									
		THEN	DONE M	. (cm			111	Penn	Stre	et,	Baltim	ore, Mai	rylan	d 2120	01			
	State	31. Date filed (Mgn)	th. Day Year)	32	Registrer's Sig	gnature	-											

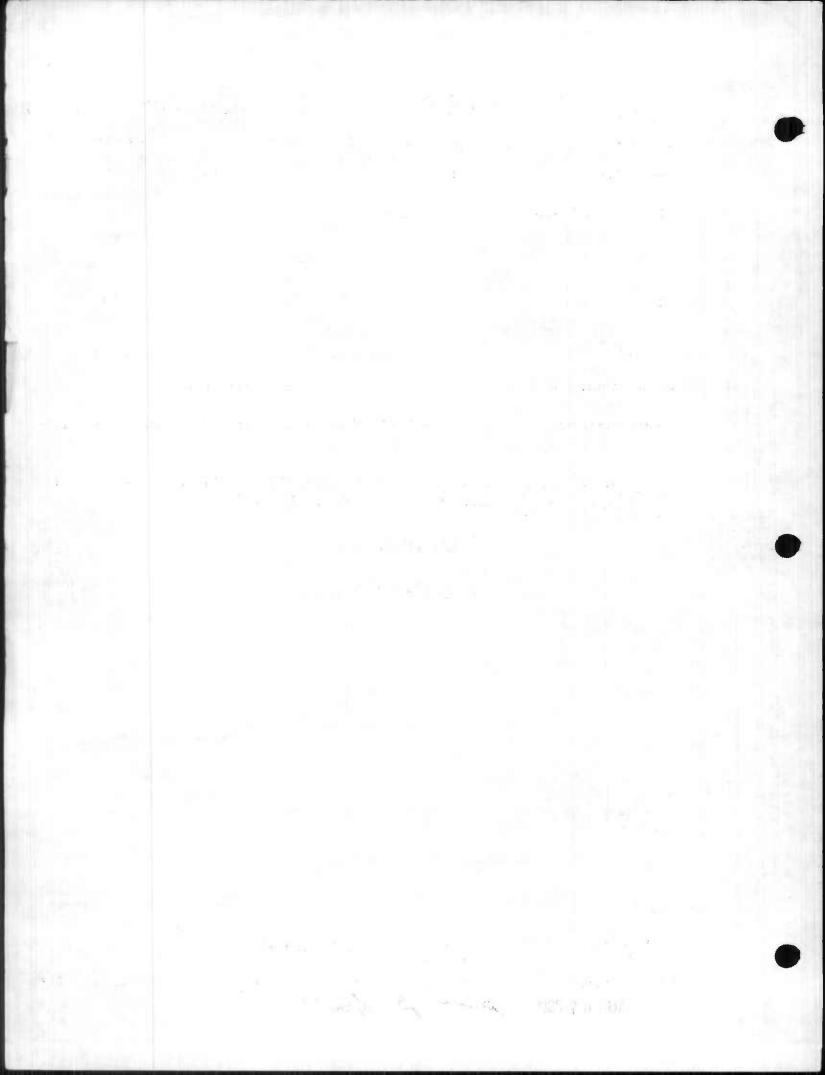
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Registrar



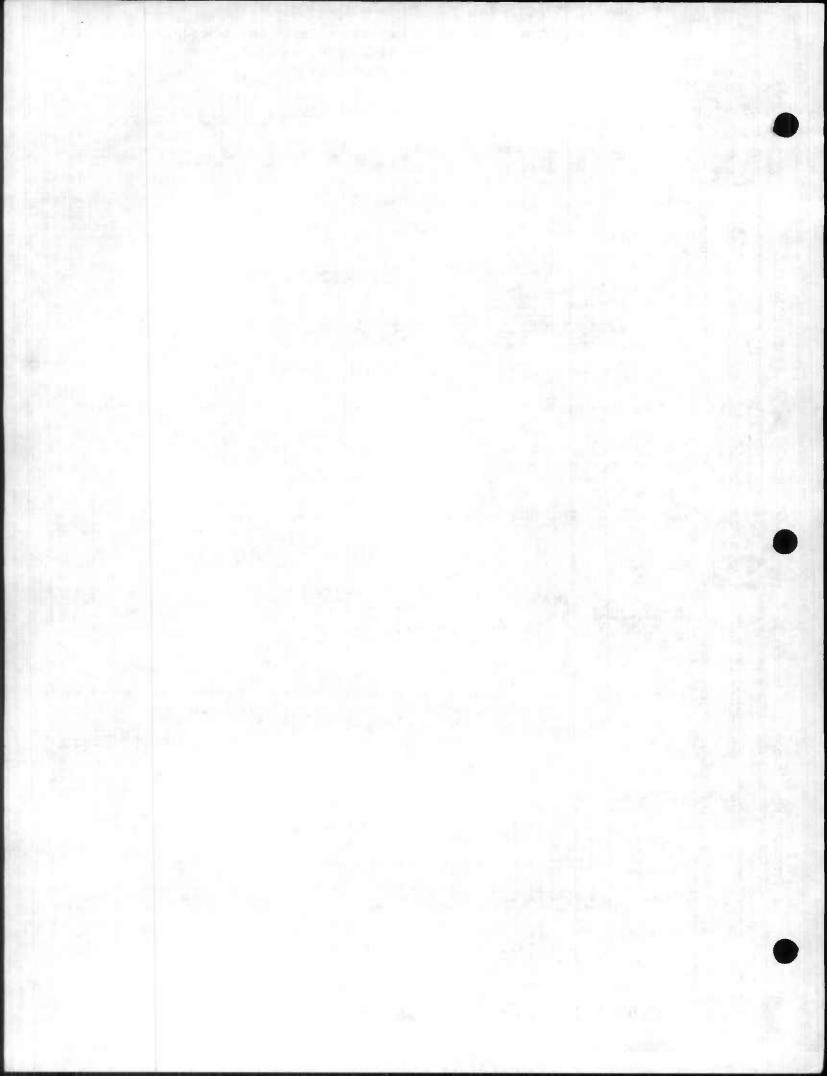
State of Maryland / Department of Health and Mental Hygiene 0 24892

					Ce	rtifica	ate of	Death		Reg. No.	61	4092
Physicia		1. Decedent's Name (First, Middle, L	ast)	al	e				2. Dete of De Month August	Dey Dey	Year	3. Time of Death
/Medic Examin		4a Facility Name (If not Institution, g	ive street and number		Noon	. ~	17	4b. City, Town, or Towson		4c. County		e
Funeral Director		124-09-4358	Sex 7. A 1 M 2 □ F		last birthday, Yrs.		ler 1 Year s Deys			th ly, Year) 1904	9. Birthpl Coun. VT	lace (State or Foreign try)
the Meryland 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Balti	more	10c. City	y, Town or L	ocation WSON					10	0d. Inside City Limits 1 ☐ Yes 2 No
th with the 23a or 28a	Funeral Director	10e. Street and Number 111 West Road				10f. 2	Zip Code	21204		10g. Citizen of W		try?
efter dea	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No No				Hispanic Origin? (San, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race Blec	e - America k, White, o	etc.
aryland 21215-0020 should be filed within 72 hours of and Mental Hygien in an armanded other than "natural", or imatic event, the Medical Exem-	Completed	15. Decedent's (Specify only highest g		r 5+)		engi:	work done use retire	pation during most of wo d)	orking	16b. Kind of Bu	vernm	
d 212 filed within Hygiene. other than	Be Co	17. Father's Name (First, Middle, Las				CIIGI	ileer	18. Mother's Ne	me (First, Middle	, Maiden Sumam		enc
Maryland d 2 should be file th end Mental Hy 7 is marked oth treumatic event	To B	Joseph Lindley H	a11					Cora	Mott Ch:	ild		
Maryla 2 should end Men is marke eumatic		19a. Informent's Neme/Reletionship	(Type, Print)		19b. Mail	ing Addre	ss (Street	and Number or F	lural Route Numb	er, City or Town,	Stete, Zip	Code)
		Richard Hall/son 20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spec			403] Place of Disp emetery, cre	osition (A	lame of	e Court	Unit 202 Date	Timoni 20c. Location -		
Baltin pemit. Pa Departmer Important any Injury pnce.		21. Signature of Fundal Service Lion Rohald S		rector			and Addre	tomy Boa	rd 655 201	W. Balt	imore	Street
Physician /Medical		23a. Part1. Enter the disease, or do slock, or heart failure. List online Immediate Cause (Final disease or condition	mplic. In is that caus y one cause on each	line.	u M S			ng, such as cardia	c or respiratory a	rrest,	1	Approximate interval Between Onset end Deeth
Examiner	liner	resulting in death)	a	De 10 (0	mas a conse	quenca o	of):					5 Yeurs
death certificate be executed death certificate be executed e ettending physicien end of for use as the bunel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	7.011	r as a conse							
Box	clan										1	
P.O. that the ed by the detache	by Physician/M	Part II. Other significant conditions	contributing to death	but not resi	ulting in the t	underlyin	g cause gi	ven in Part I.				the causa of death? bably 4 2 Unknown
aw requ	Completed b								24e. Was	s en eutopsy ormed?	av	ere autopsy findings eileble prior to mpletion of cause death?
	Con								1 🗆	Yes 2 No	10	Yes 2 No
of Vital B Physician: The	Be	25. Was case referred to medical examiner?	Hospital:				Ot	han d	eth (Check only			
0 5 5 6	-T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Li Inpa		ER/Outpatie		DUA	4 Minursing	-	how Injury occur		V)
Attanding or death.	Certification:	1 Natural 5 Pending Investigati 3 Suicide 6 Could not determine	be on Disease of I		Injury	М	1	Yes 2 No	28f. Location	(Street and Numb		nl Route Number,
To the Hospital or within 24 hours efte To the Funeral Dir completely filled in		29a. Certifier 1 ☑ Certifying F	Phyalcian: To the besimmer: On the besis	at of my kno of examina	wledge, dea	th occurre	ed et the ti	ime, date and place	a, and due to the	cause(s) and me	enner as s	tated.
To the I within 2 To the I complet	Medical	29b. Signature and title of certifier	and manner :		lysin			se number 3642		29d Date signed		
		30. Name and eddress of person who	3007	death (Item	23a) (Type	Print)	n 1	Park W	ay Ba	et mor	10	21214
Sta	te	31. Dete filed (Manth Pay Year) 2	000 32. 8 94	strar's Sions	tura 6.	1	boul	21				



State of Maryland / Department of Health and Mental Hygiene

	11.00			Ce	ertificate of	Death		Reg. No.	24893
	Physician	1. Decedent's Neme (First, Middle, Las			111112		2. Date of De Month		3. Time of Death
N.	/Medical	Andrew Johnson,				4h City Tourn	August	5, 2000 Y	8:00AM
	Examiner	4a Fecility Neme (If not institution, give 9218 A Avondale F	Rd.			Parkvil		th 4c. County of Baltim	
	Funeral Director	5. Sociel Security Number 6. Sc 078-22-2381	ex 7. Age (In yr.	7 1 Yrs.	Months Days		in. (Month, De		Birthplaca (State or Foreign Country)
	pud &	Usuel Residence of Decedent 10a. State 10b. County	100.0	City, Town or U	ocation				10d. Inside City Limits
	4 aho			arkvill					1 ☐ Yes 2 ☑ No
	or 28a-f all pe norther	10e. Street and Number			10f. Zip Code			10g. Citizen of Who	at Country?
	th will		d		21234			USA	
Maryland 21215-0020	72 hours after death with the Maryland neturel; or items 23s or 28s-f show finel Examiner must be notified at the by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1. Yes 2 □ No If Yes, Give Yeer or Detes:	U,S. 13	Wes Decedent of If Yes, specify Cui	ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		American Indian, White, etc.
5-0	naturef,	15. Decedent's Ed (Specify only highest gra-	ucation de completedì	16e. Dec	edent's Usual Occu	ipation during most of v	vorkina	16b. Kind of Busin	
121	ed within 72 ho yglena. Pyglena. Pyglena. Pyglena. Pyglena. Pyglena.	Elementary/Secondary (0-12)	College (1-4or 5+)		PO NOT use retin			Erie Loc	
d 2	EIBE			Cal	inspecto	T	leme (First, Middle	Railroad o, Maiden Sumame)	
lan	Dad o					Anna			
lary	and and	19e. Informent'e Neme/Reletionship (7	Type, Print)					per, City or Town, St	
	f Heelth frem 27 i	Andrew Johnson	loo-		A Avond	ale Rd.,		le, MD 21:	
Baitimore,	Peges ent of rt: If Ib	20e. Method of Disposition 1 🖾 Buriel 2 Cremetion 3 C 4 Donation 5 Dother (Specify	Removel from State	cametery, cr	emetory or other pl		Aug 9	20c. Location - Ci Woodbrid	
Bai	Departme Departme importan any injur pace	21. Signature of Fureiral Service Licen	alolk	2	22. Name end Add Evans Fu 8800 Har	neral Ch	Parkvi	lle, MD	
		shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not e	nter the mode of dy	ring, such as card	liac or respiretory of	errest,	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	(010)	140-1	10 +12	7114	70-		3
	Examiner	disease or condition resulting in death)	0.	(or es e cons	ARTER:	7 10100	HIL		Loyars
	D = G			THE REAL PROPERTY.	MELLI	rus			1 4800
	axecuted in and ial-transit	Sequentially list conditions,		(or as e cons					
68760,	icata be axecuted physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	· TOBALL						
	\$ 0 d		d	(or as a conse	equence or):		•		
Box	at the death certached by the attendir etached for use	Part ti. Other significant conditions co	potributing to double but not s	autina in the	underlying cause o	in an in Bort I	22h Did	I tobacco use contr	ibute to the cause of death?
P.O.	the ch	Part II. Other significant conditions co	ontributing to death but not re	suiting in the	underlying cause g	iven in Petti.		/	□ Probably 4 □ Unknown
	5 60 >								
Records,	shour ete						24a. Wa: perl	s an autopsy ormed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
	The law ate has pege 2						10	Yes 20No	1 ☐ Yes 2 ☐ No
Vital	entific setor	25. Was case referred to medical examiner?	Hospitel:				Death (Check only	one)	
o	His High	1 Yes 2 No	1 □ Inpatient 2	☐ ER/Outpeti 28b. Time	ent 3L DOA			how injury occurred	
lon	Attending is redeath. setor: After by the funer liftcation:	1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	Injury	W	ork? ⊒Yes 2□No			
Division	or Att	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, ferm, s	street, fectory, office		28f. Location City or To	(Street end Number own, State)	or Rurel Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 12 Certifying Phy (Check only one)	ysician: To the best of my kr ilner: On the basis of examin end menner steted.	nowledge, dea netion and/or l	ath occurred et the Investigation, in my	time, date end pla opinion, death or	ace, end due to the ocurred at the time	cause(s) and mann , date and placa, en	ner es stated. d due to the cause(s)
	within To the	29b. Signature and title of cartifier	1)	1	29c. Licer	nse number	FE I	29d. Date signed (Month, Dey, Year)
	7	Dewil 1.	frauv	-/h]) P12	349		8/7	100
	7. W	30. Neme and address of person who do	Empleted cause of deeth (Ite	om 23e) (Type	BALTIMO	CEVA	KNGRE	TEME ST	BACT, MS 21701
	State Registrar	AUG 0 8 2000	32. Registrer's Sig	*	books				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** . 45 JOHNSON EVILLE AUG 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner HOICE SVILLE ALTIMORE DEN ATON If Under 1 If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) **Funeral** Days Hours Min. 1□M 2/□F 82 Director 217.07.7341 Oct. 22, 1917 Virginia Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits flams 23s or 28s-f show MD Baltimore Catonsville 1 ☐ Yes 2 🛣No the Medical Examiner must be notified Directo 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 719 Maiden Choice Lane #223 21228 U.S.A. Funeral 12. Was Decedent Evar in U.S. Armed Forcas?

1 X Yes 2 No H Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 72 hours after 1 ☐ Nevar Marriad 2 ☐ Married "natural", or Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à XIXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Secretary Secretarial Department of Health and Mental Moperaters of Health and Mental Men 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Be. 10 Julian E. Carroll Bernice Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #215 Lane 228 719 Maiden Choice Anne Lowe/Sister Catonsville, MD 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burlal 2 Cremation 3 ☐ Removal from State 8/5 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Gary L. 21. Signature of Funeral Service Licenses Kaufman Funeral Home ell 7250 Washington Blvd. Elkridge, MD 21075 Effect the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, or heart fallure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical mediate Cause (Final ear disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examine Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, The law requires that the death certificate be Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 4 been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed this certificate has 1 Yas 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of after death.

Director: After ti
d in by the funera 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide filled in I within 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29a. Certifier Medical npletely \$ 29d. Date signed (Month, Dev. Year) 29b. Signaturi 29c. License number 2 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) hoice Lane, Catorsville, MD 21228 Phillip Maiden Stone

Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

AUG 0 8 2000

oaks

32. Registrar's Signature

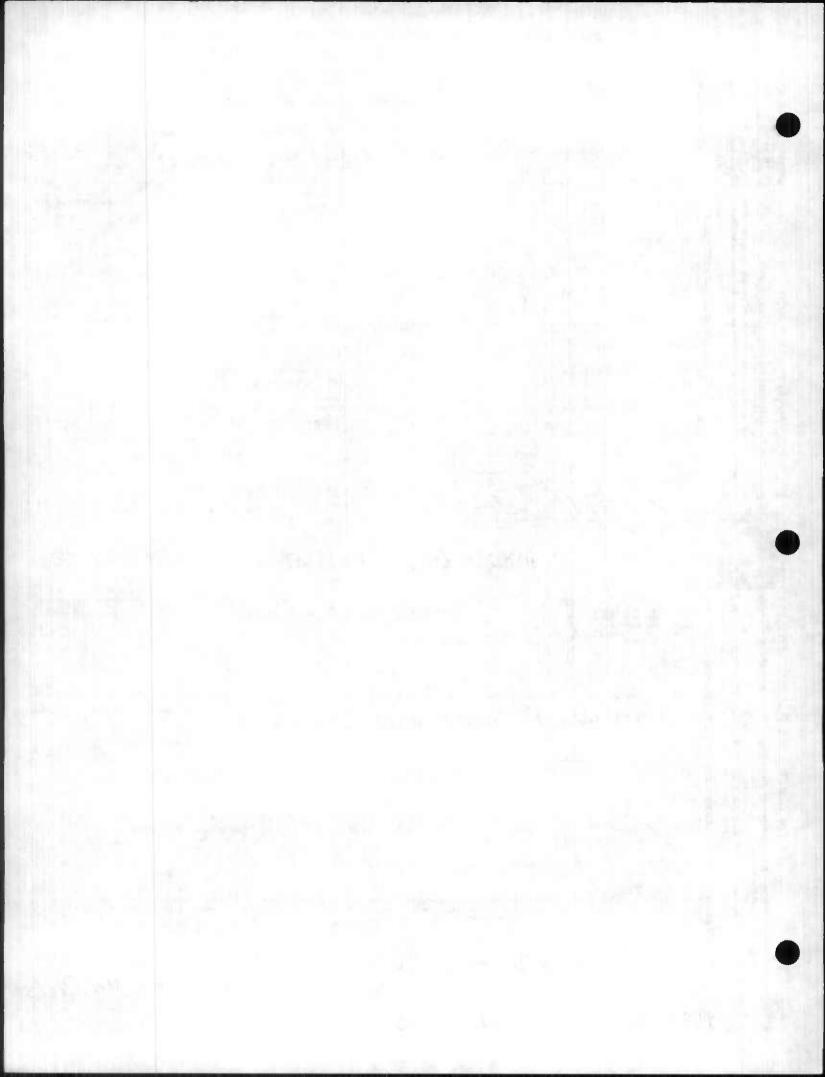
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

UL

24895

			06/	lilicate of	Dealli	R	eg. No.	0 2 0		
Physician /Medical	1. Decedent's Name (First, Middle, L HELEN	K.	KAPI	LAN		2. Dete of Deel	4 ^{ay} 2000	3. Time of Death 8:30PM		
Examiner	4e Facility Name (If not institution, game MILFORD MANOR		номе		4b. City, Town, or L BALTIM	ocation of Death ORE	4c. County of De BALTIN	ath IORE		
Funeral Director	5. Sociel Security Number 6. 213-36-4159 Usual Residence of Decedent	Sex 1□ M 2∏ F	(In yrs. last birthday) 75 Yrs.	If Under 1 Yeer Months Days		8. Date of Birth NOV ^{nith} 5 ^{ay} 19724 P		Birthplace (State or Foreign		
pus m	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
with the Maryland a or 28a-f show Lbs northed at	MD HOWAR	D	ELLICOTT	CITY			1 Yes 2 □ No			
with the Ma	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?		
th wit	8543 WHEATFIEL	D WAY		21	043		U.S	5.A.		
fler death v	11. Mental Stetus	12. Wes Decedent E Armed Forces?	ver in U,S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Ar Bleck, W	merican Indian, hite, etc.		
by	3X Widowed 4 □ Divorced	1 Yes 2 N If Yes, Give Yeer or Detes:	0	1□Yes 2□No	Specify:		Specify: V	VHITE		
ed within 72 hours at ygiens. "neture!", or it, the Hedgel Engli	15. Decedent's E (Specify only highest g	Education rade completed)	16a. Deced	dent's Usual Occu kind of work done	petion during most of worked)	king	16b. Kind of Bustne	ss/Industry		
Jena. Than "	Elementery/Secondery (0-12)	College (1-4or 5	4)		nologis'		MEDICINE	0		
		at)	THEFT	AB IBCD			Maiden Sumame)			
B cost	VEGUTER	KL	AR		RAISEL		JNKNOWN)			
	19e. Informant's Neme/Relationship	(Type, Print)	19b. Mailir	ng Address (Stree	and Number or Ru	ral Route Number	r, City or Town, State	a, Zip Code)		
	JOSEPH A. KAPL	AN/SON	8543	WHEATF	TELD WAT	Y ELLIC	OTT CITY	Z,MD.21043		
0 - 2 0	20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of matory or other pla	ace)		20c. Location - City	or Town, State		
Page nent o nrt: If	Washington 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ANSHE E	BHEREGA		3/6/00	BALTIMOR	RE, MD.		
pemit. Pag Department Important: if any injury o	21. Signature of Funeral Service Lice	ensee	22	. Name and Addr	ess of Facility	2222	N.C			
Dep Imp	Acotto VI	1. Cuth	1/1		NSON &		NC. PIKESVII	LLE, MD 21		
certificate be axecuted ding physician and ise as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):									
death e atter od for u	Part II. Other significant conditions	dcontributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23b. Did to	obacco use contrib	ute to the cause of deat		
requires that the seen signed by the hould be detache eted by Physe	1 (Meter	mel	ctis			1 U Y	'ee 2□ No 3□	Probably 4 Dunkho		
has been signed 2 should be						24a. Wes e perior		 Were autopsy findings available prior to completion of cause of deeth? 		
The la						1 🗆 Y	es 211 No	1 ☐ Yes 2 ☐ No		
certificate rector, pag	25. Was case referred to predical examiner?	Hospital:				th (Check only or	ne)			
His I di	27. Menne of Deeth 1 Natural 5 Pending	28a. Date of Injur (Month, Day	2 ER/Outpatier 28b. Time of Injury	28c. Inju	-		ence 6 □Other (S ow injury occurred	pecify)		
the the	2 Accident 3 Suicide 6 Could not determined	be 28e Place of Inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (S. City or Town		Rural Route Number,		
Hoep 14 hou Fune tely fil	29a. Certifier 1 Certifying P	thysician: To the best of miner: On the besis of and manner sta	examination and/or in	n occurred at the t vestigetion, in my	ime, dete end place opinion, death occu	, and due to the c rred et the time, d	euse(s) end manner late and place, end d	as stated. due to the ceuse(s)		
To the He within 24 To the Fi	29b. Signature and title of certifle			29c. Licen	ise number	2	9d. Date signed (Mi	onth, Day, Year)		
4	1 the	The	e, M()	11510	10 1	AvasT	- 5,2000		
W	30. Name and address of person who	SHINGI	uc E	Print)	IK Ht.	The,	BAT	MA MOL		
State	31. Dete filed (Month, Day, Year)	32. Registra	r's Signature			1	,			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

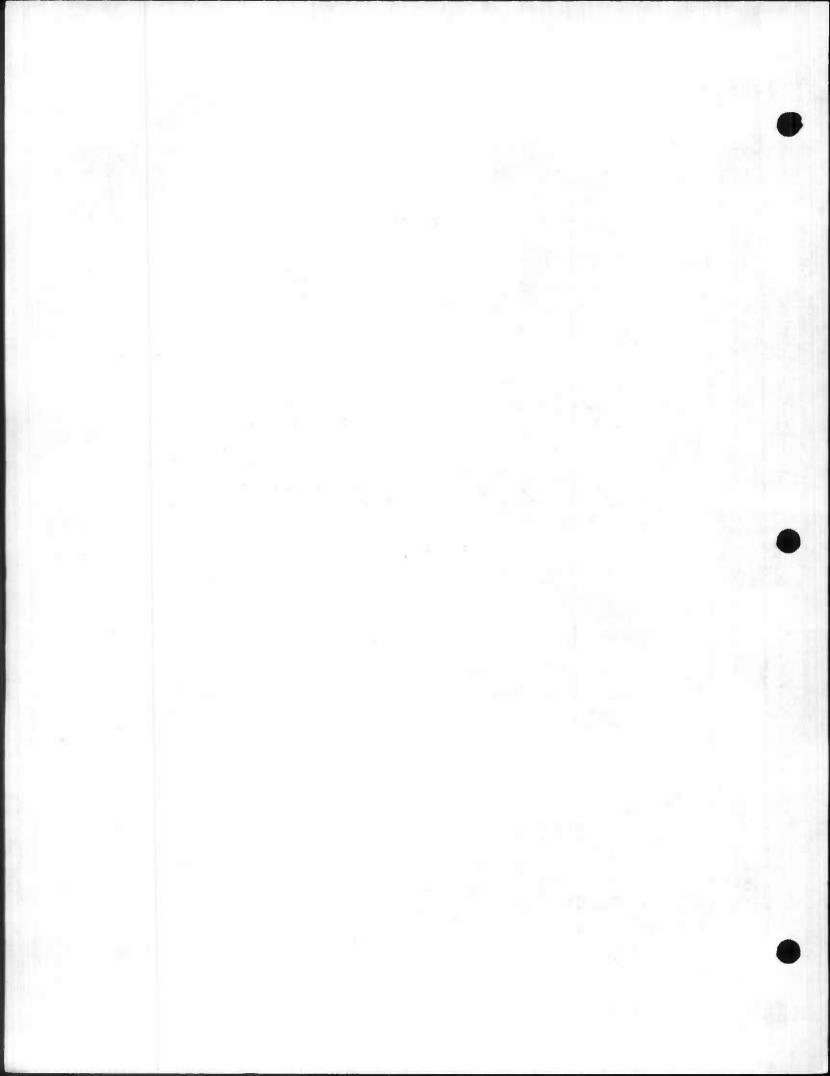
Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 12:26 VIRGINIA 08 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ANNAPOL If Under 24 Hrs. ANNE ARUNDEL MEDICAL CENTE ANNE ARUNDEL If Undar 1 Year 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2XX Days 216-20-4377 22, Director 73 1926 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examiner must be nothing at 1 Yes 2 No Director Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1310 Ashburton Drive 21108 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, While, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2\(\)No If Yes, Giva altimore. Maryland 21215-0020 1 Yes 25 No by If Yes, Giva Yaar or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if flem 27 is marked other any lojury or other traumatic event obtas. 17. Father's Nama (First, Middle, Last) Be Elmer Edward Ritter Victoria Laginski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Alfred Joseph Kral (Husband) 1310 Ashburton Drive, Millersville, MD 21108 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stale 20e Method of Disposition 08/07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2000 Davidsonville, MD 4□Donation 5₺Other (SpecifyEntombment Lakemont Memorial Gardens 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapoli cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Kicke 23a. Part1. Enter the disease, or complications shock, or haart feilure. List only one cause Approximate Intarval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical & EXACERBATION OF UNDERLYING CARDIAC CONDITION **Examiner** Dua to (or as a consaquanca of): Examine slcian and burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of) physician Box 68760 Physician/Medical the Due to (or as a consequence of) 88 the attending 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown yd bengis MITKAL/TRICUSPIAREGURG. þ Division of Vital Records, 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an eutopsy performed? Completed page 2 s certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpalient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Manne of Death 1 Matural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation after death.
I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by or A after 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner steled. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nama and addy ss of person who completed cause of death (Item 23a) (Type, Print) RITCHIE HIGHWAY SEVERNA PARK, MP 21146 ITTLEK 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State AUG 0 8 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene

			rate of marylans	Certifica	ate of	Death		Reg. No.	2	4897
		1. Decedent's Name (First, Middle, Last)		The same			2. Dete of De	ath		3. Time of Death
	Physician	Pe	ter Lepper	t			August	5, 2000	Yeer	10:35 a. m.
	/Medical Examiner	48 Facility Name (If not institution, give stre				4b. City, Town, or E				
		Gilchrist Center			7	owson		Balt	imore	
	Funeral	5. Sociel Security Number 6. Sex	7. Age (In yrs. I	ast birthdey) If Und	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th Yearl	9. Birthpla	ace (Stete or Foreign
	Director	217-09-7206	2□ F 90	Yrs.	ns Deys	nours Min,	March 5	, 1910	Mary]	
100	2	Usual Residence of Decedent								
	ith the Marylar or 28a-f ahow a notified at	Maryland Baltimore	10c. City	r, Town or Location	T.T a	dlawn			10	d. Inside City Limits 1 Yes 2 No
	the Maryla 28a-1 aho notified at					diawn				4.
	with the Maryland to or 28a-f ahow the notified at	10e. Street and Number		10f.	Zip Code			10g. Citizen of V	Vhat Counti	ry?
	5 2 0	6705 Windsor Mill R				21207		United S		
	ter dea	11. Merital Status	Wes Decedent Ever in U.S Armed Forces?	S. 13. Wes De If Yes, s	pecify Cub	lispenic Origin? (Sp an, Mexicen, Puert	Rican, etc.)	Blac	e - America k, White, e	
20	or after	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No	Specify:		Specify	Whit	te
35 Maryland 21215-0020		15. Decedent's Educat		16a Dacadent's II	leual Occur	etion		16b. Kind of Bu		
15	c •	(Specify only highest grade of	ompleted)	16a. Decedent's U (Give kind of life. DO NO	work done T use retire	during most of world)	king	Tob. Nind St Do		
212	Jane.	Elementary/Secondery (0-12) 8th	College (1-4or 5+)	Carpente				Self-Er	nn I owa	a d
D	be filed of other event, I	17. Father's Name (First, Middle, Last)		ourpence	1 4 5	18. Mother's Nan	e (First, Middle,			
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NAZ	d 2 should the and Mer 7 is marke traumatic	19e. Informant's Neme/Relationship (Type,		19b. Mailing Addr	ess (Street	and Number or Ru			State, Zip (Code)
W Z	nd 2 lifth e 27 Is r tra	Mary R. Leppert	(Wife)	6705 Win	dsor :	Mill Road	Woodl	awn, MD	21207	7
/C	f Her fem other	20e. Method of Disposition	20b. Pl	lece of Disposition (/	Neme of	ce)	Date	20c. Location -	City or Tow	m, State
e e	Pege ant o nt: If ry or	Marial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	loval from State Woo	dlawn Cem	etery	August 8	, 2000	Woodlav	vn, Ma	aryland
00 / Baltimore	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr ance.	21. Signature of Funerel Service Licensin		22. Name	end Addre	ss of Facility Lon	ing Bye	rs Funer	al Di	irectors, In
2000 Ba	Dep Per Suppose	1 Chand Oth	00	8728		ty Rd. Ra				
0		23a. P W Enter the disease or complice	ions that ceused the death		node of dyle	ng, such as cerdiad	or respiretory e	rrest,		Approximete Interval Between
R	Physician	or heart teilure. List only one								Onset and Death
7	/Medical	Immediate Ceuse (Finel disease or condition	Mysen	deal .	Wa	relian			1	1 day
3	Examiner	resulting in deeth) e. ~	Due to (or	ras e consequence arting	of):					
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0	iste be executed hysician and the burial-transit	Sequentially list conditions,	Due to (or	r es e consequence	of):		Media			
ا فرا	be exe	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events								
378	physicians the burner of the b	thet initieted events resulting in death) Last	Due to (or	es e consequence o	of):					
O X		d								
0	attendin for use			4431/4						
20	The lew requires that the death certate has been signed by the attending page 2 should be detached for use Completed by Physician/N	Part II. Other significant conditions contrit	outing to death but not resu	ulting In the underlyin	ng ceuse giv	ven in Part I.				the cause of death?
30.	that the de ned by the detached	Chrome osstricti	ve pulmo	nay	dufer	ne	10	Yes 2 No	3 Prob	ebly 4⊠Unknown
S,	een signe hould be	NICI		0			24e Was	en eutopsy	24b. We	re eutopsy findings
200	been shoul	Typewoo de	sease				perfo	ormed?	sva	allable prior to appletion of ceuse deeth?
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No. of the last of	certificate hir rector, page	Juan Juanu	avvivo				10		111	Yes 2 No
Division of Vital	Physician: this certific rai director,	25. Was case referred to medical examiner?	pitel:		DOA OII	26. Plece of Dec		1/		Hurul
ō	Physic this cerai dire	TEL TES ZIM NO	1 Inpatient 2 2	28b. Time of	DUA	4 LI Nursing n		how injury occur		1117
u o	After funer	1 Naturel 5 Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2□No				
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Di N	245 T	4 Homicide	building, etc. (Specify	1)			City or To	wn, Stete)		
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	in 24 hour in 24 hour he Funer plately fill	(Check only 2 Medical Examiner one)	 On the basis of examinet end menner steted. 	ion end/or investigat	lion, in my o	pinion, death occu	rred at the time,	date end plece,	and due to	the ceuse(s)
	To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29b. Signature and title of certifier	11 (M)		29c. Licens	se number	15/1	29d. Date signe	d (Month, E	Dey, Year)
	1	Murda	MY		13	0433		8/5	100	
	dx,	30. Name and address of person who comp	jeted cause of death (flem	23a) (Type, Print)	1	117.00	1015	200	7/ 1/	211
1	8	(12MC 6101 N	unincues	31	5	ALTIMO	KB	MO	2120	7
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1	Registrar	AUG 0 8 2000	Reper	10 1	went	3				

DHMH 16 Rev 6/95

			State of Ma	aryland		tment of t ificate of	nealth and I Death	Mental Hy	/giene	0' 2	21,202
	1. Decedent's Nem	e (First, Middle, Last)					2. Dete of D	eath	0 2	3. Time of Death
Physician	KODETT	н.	La	amb				Month Augus	t 7	Year 2000	2:00 a.m.
/Medica Examine	And Affirm Parks and Advanced A	If not institution, give	street and number)				4b. City, Town, or I	Location of Dea	th 4c. County	of Deeth	
		Eldercare	e - Spa Cr	ceek			Annapol	is	Anne	Arund	le1
Funeral	5. Social Security N	lumber 6. Se	x 7. Age	e (In yrs. la:		If Under 1 Year Months Days					lace (State or Foreign
Director	220-05-0	1216	XM 2□ F	80	Yrs.	Working Days	I ROUIS NIII.	May 17	, 1920	Mary	land
pu a	Usual Residence of	Decedent 10b. County		10c City	Town or Loca	tion				10	0d. Inside City Limits
ahow			n a o 1								1 ☐ Yes 2 ☑ No
the Management	MD 10e. Street and Nu	Anne Aru	ndel	Ann	apolis	10f. Zip Code			10g. Citizen of V	What Coun	
death with the Maryland me 23a or 28a-f ahow matt be notified at	25.70 Pir	a Road, #.	130		4-7-1	2140	11		USA	viiat oouit	uyr
w 23e	11. Marital Status	α Road, π.	12. Was Decedent E	Ever in U.S.	13 Wa		The second second	nacify Vas or N		e - Americ	an Indian
020 urs after al., or the	1 □ Never Mari	ied 2 Married 4 □ Divorced	Armed Forces? 1 □ Yes 2 □ N			es, specify Cub	lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Blac Specify	k, White,	
72 hours	(500	15. Decedent's Edu				nt's Usual Occup	pation during most of wor	kina	16b. Kind of Bu	usiness/Inc	Justry
21 Period	Elementary/Sec		College (1-4or 5	+)	life. DO	NOT use retire	d)	nany	PORCE.		
d 21 Hygien w ther th	(Special Control of Co				Progr	rammer	Y		Compu		
Du dia di di di di di di di di di di di di di	17. Father's Name	(First, Middle, Last)							e, Maiden Sumam	ne)	
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Maryiand d 2 should be file th and Mental Hy T Is marked othe treumatic avant		eme/Relationship (7) L. Lamb (1)					and Number or Rule 4 , 13 C,				
Health Health Lam 27 I other tr	20a. Method of Dis		nite/	20b. Pla	ce of Disposit	ion (Name of		Dete	20c. Location -		
DOI of of of of of of of of of of of of of	XIX Burial 2	Cremetion 3 P				cemeter	ce)	08/10	Annapo1	is. N	MD
Baitimore, Maryiand 212: pemit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other treumstic avant, to all		5 Other (Specify) megal Service Lipans	,	/		Name end Addre		2000	mmapor	.15/ 2	
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	23a, Pert1, Enter I	he disease, or compl nt leilure. List only or	ications that caused	the death.			ly Avenue			2140	Approximate
Physician	shock, or hee	nt leilure. List only or	ne cause on each lin	10.							Onset end Death
/Medical	Immediete Cause	(Final		Ta	hom		ardiony	. (0		1	60m
Examiner	disease or condition resulting in death)	ari .	E	Due to for a	as a conseque	ince og.	mar and	abarr		1	00.1
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Of Vital Re Physician: The interpretation of the continuate harmonic and director, page	1 TYPE 2	*No I	lospital:	nt 2 E	R/Outpatient	3 DOA O	ham t -		sidence 6 Oth	er (Specify	y)
0 5 5 8			28a. Date of Injur (Month, Day	y Year) 2	8b. Time of Injury	28c. Inju Wo			how injury occur		
bath.	2 ☐ Accident	5 Pending investigation					Yes 2□No				
Division of all or Attending Parts at Director. After led in by the funer	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	iry - At horn . (Specify)	e, larm, stree	t, lactory, office		28I. Location City or To	(Street end Numb own, State)	er or Rura	I Route Number,
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Division o To the Hospital or Attending Ph within 24 hours siter death. To the Funeral Director: After th completely filled in by the funeral	29a. Certifier (Check only one)	2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	examinatio							
To the To the Complet						29c Licens	se number		29d. Date signe	d (Month,	Dey, Year)
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1.11	30. Name and edds	ess of person who co	impleted cause of de			int)	1 000	- 10 - 6			
W	0071	grove	- 0	adro		Car	W. MI	21619	1		
State Registrar	31. Date filed (Mon	In, Day, Year)	32. Registra	ir's Signatu	19	Spork	2				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | amend item 18,19 per fh G786 8/8/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LEVITZ AUGUST 4, 2000 6:55 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUN 24, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2▼F 79 Yrs. MD Director <u> 216–16–1531</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11423 REISTERSTOWN ROAD 21117 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 1 ☐ Yes 2 🖾 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Symage) Pinchosbovitz Maryland 17. Father's Name (First, Middle, Last) ould be Mental SAMUEL BUDEN ANNA PHINCH COLOR VINEYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis LEVITZ / HUSBAND if Health Nam 27 I 3123 WALNUT AVENUE - OWINGS MILLS, MD 21117 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH JACOB CEMETERY 8/6/00 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyhr II Service Line 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. 23a. Part1. Enter shock, or he Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Brain metastatic 1 munth Examiner Due to (or as a consequence of):

DOSSIBLY DURIAN Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): USB BS P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 1 Yes 200 No 1 Yes 2 No of Vitai or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) To. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending Injury after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled edical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

29b. Signature and title at certifie

31. Date filed (Month, Day, Year)

AUG 0 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MC

32. Registrar's Signature

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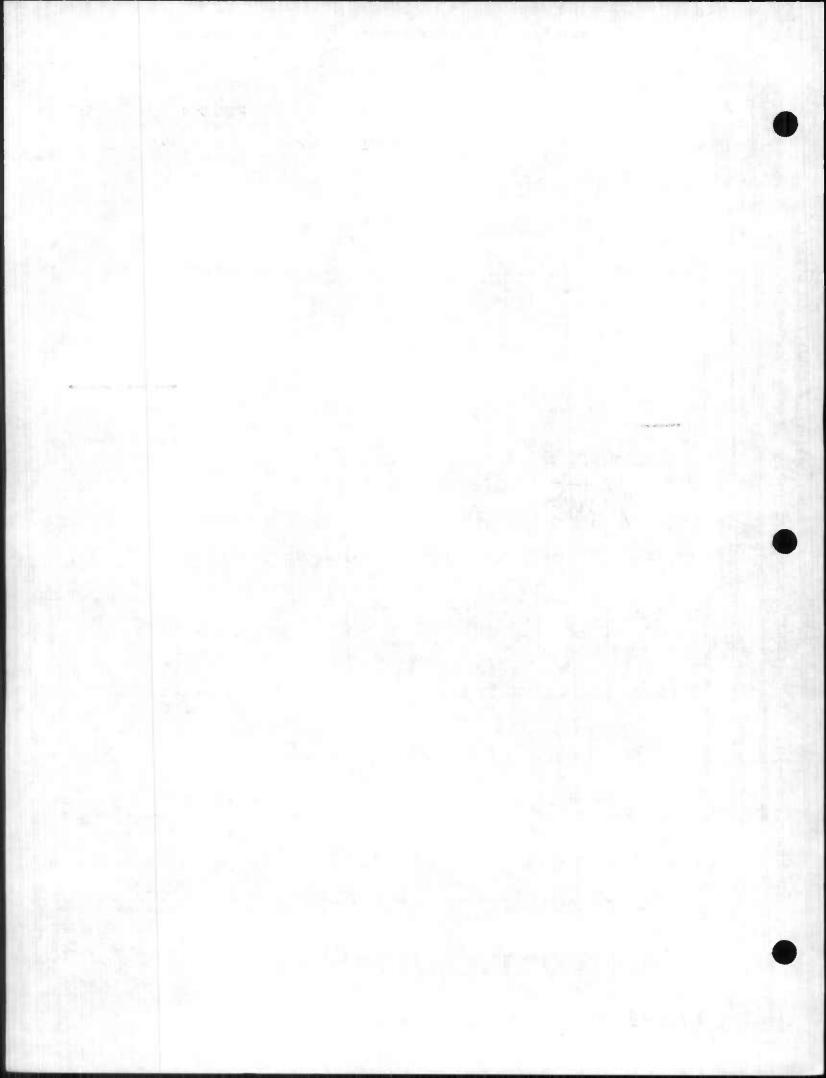
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29c. License number

N. Charles St.

29d Date signed (Month, Day, Year)

2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** 6:00P.m August Kathleen Lee 2000 /Medical 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200F 89 9/18/1910 Director 219-96-5651 **England** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yas 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r then "naturel", or items 23a 201 Glouchester Drive 21061 Great Britain Funeral 14. Race - American Indien, Bleck, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes ② XNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Werried 1 ☐ Yes X No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Lambert Winnifred King 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: if item 27 is eny injury or other tra once. Olive Harrison - daug. 201 Glouchester Dr., Glen Burnie, MD 21061 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Steta 1 XX uriel 2 ☐ Cremation 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Glen Haven 8/4/00 Glen Burnie, MD of Fundal Service Licensee 22. Name and Address of Fecility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical AZRIRATION Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): HUPERTENSION Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 12 No 1 ∏ Yes 2 ∏ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Monpatient 2 ER/Outpatient 3 DOA Certification: To 27. Menner of Deeth 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide □ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NW 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dans, Glen Burnis. ms. 21061. HASTAL 301 Glejus AUG 0 8 2000 33 Registrar's Signetura

State Registrar

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To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi

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Box 68760,

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Records,

Division of Vital or Attending Physician:

The law requires

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a or 28a-f show be notified at

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Gaye Mary Meninger 2000 2 9:05 PM August /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 1 M 2 X F Director 76 5/29/1924 193-18-5822 Speedwell, VA the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits rail, or items 23a or 28a-t show Examiner must be notified at Md Harford Fallston 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2812 Harford Road 21047 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 72 hours after 1 Yes 2 No 1 Never Merried 2 Merried 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Yaar or Detas: ind 2 should be filed within 72 hou alth and Mental Hygiene.
27 Is marked other than "natural in traumatic avant, the Medical E. Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) unknown Food Preparer Notchcliff Retirement Home Baltimore, Maryland 17. Fethar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Pages 1 and 2 should be finant of Health and Mental 9 int: if Itam 27 is marked of Rybern Clinton Hawks Stella Mae Hackler 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and Department of Health Important: if ham 27 any Injury or other tr page. 2812 Harford Rd. Fallston, MD 21047 Judyth Tombaugh (Daughter) 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Highview Memorial Gardens 8/5/200 Fallston, MD 22. Name and Address of Fecility of Funeral Service Licenses E.F.Lassahn Funeral Home 23 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert tailure. List only ona causa on aach lina. Approximete Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Finel disaase or condition resulting in death) Chronic Obstructive pulmonary disease Years Examiner Due to (or as a consaquence of): Examiner physician and s the bunal-transit be executed Sequantially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequance of): Box 68760. Physician/Medical Due to (or as e consequenca of) signed by the al Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. TO Yes 2 No 3 Probably 4 Unknown Chronic atrial fibrillation Records. þ 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Wes en eutopsy performed? has 1 Yes No 1 Yas 2 No Division of Vital 25. Was case referred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Sursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Mannar of Deeth 28e. Data of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After or Attanding 5 Pending investigation 1 Yas 2 No death. 2 Accident after deatl Diractor: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide hours 8 Hospital 24 hours The Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner steted. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number when 3,2000 August D0053186 30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 615 W. McPhail Rd Bel Air, MD 21014 JULIE TIMMEY MD G 0 8 2000 32. Registrar's Signature

Dailes

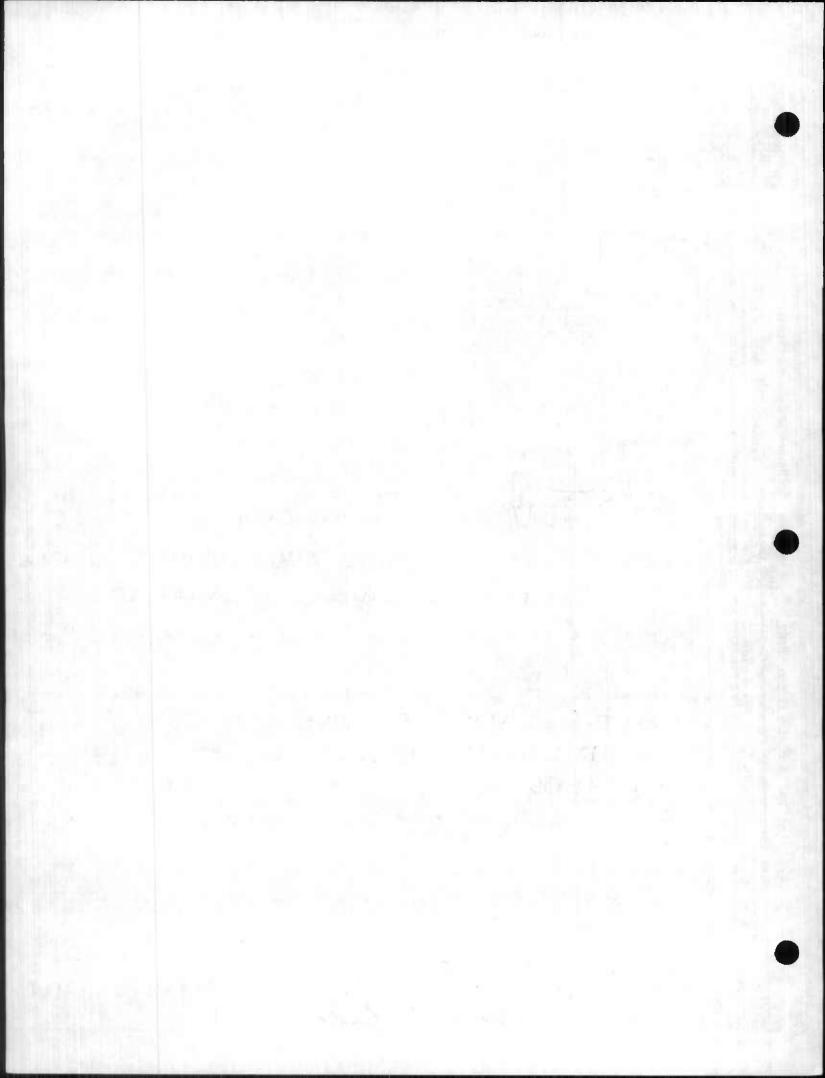
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2000 AUG -8 PM 12: 47

State of Maryland / Department of Health and Mental Hygiene 00 24902

40.00	Certificate of Death	Re	eg. No.	24902
Physiciar	1. Decedent's Name (First, Middle, Last) John Richard Morton, Jr.	2. Date of Deat Month	Day Year	3. Tima of Death
/Medica Examine	As Callity Marce 18 and institution with a street and author)	August Location of Death Dre	4c. County of Death	10:30 Pm
Funeral Director	5. Social Security Number 217–52–2629 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year 1 Wonths Days Hours Mir	. (Month, Day,	Year) 9. Birth Con Md.	nplaca (State or Foreign untry)
with the Maryland a or 28a-f show Le notified at	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location Baltimor	e		10d. fnside City Limits 10d Ves 2 □ No
th with the	10e. Street and Number 1051 Stoll Place 1. Menitel Stetus 1. Never Married 2. Married 1. Yes 2. Amed Forces? 1. Never Married 2. Married 2. Married 2. Amed Forces?	11	0g. Citizen of What Cou USA	untry?
urs of	3 Wildowed 4 Divorced Year or Dates:	Specify Yes or No- rto Rican, etc.)	14. Raca - Amer Black, White Specify: Bla	e, etc.
swithin 72 ho piene. r than "natur the Mexical	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 9th Grade 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) Truck Driver	orking	P.J. Contr Company	,
2 should be filed and Mentel Hygis s marked other numatic event, I	17. Father's Name (First, Middle, Last)	mme (First, Middle, May Dawso		
	19a. Informent's Name/Relationship (Type, Print) Joyce A. Morton 19b. Mailing Address (Street and Number or F			lip Code)
200	20a. Method of Disposition 1 Burial 2 Peremation 3 Removel trom State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Name of cametery, crematory or other place) Metro Crematory	1	20c. Location - City or 1	
permit. Pages Depertment of Important: If it any Injury or o	21. Sonator of Funda Sprice Licensee 22. Name and Address of Facility Na 2501 Gwynns Falls	utter Fund	eral Homes,	Inc.
- CD	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of):			Interval Between Onset and Death
the death certified by the attending tached for use a	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco usa contributa	to the causs of death?
res thet the signed by be datac	DIABETES NEART FAILURE,	1 🗆 Y	7	robably 4 Unknown
The law requires that the death cert alse has been signed by the attending page 2 should be datached for user from the stranged by Dhysician M.	MORBID OBESITY, HYPERTENSIO	N 24e. Was a perform	med?	Were autopsy findings available prior to completion of cause of death?
Iclen: certific rector	25. Was case referred to medical examiner?	eath (Check only on	ne)	cify)
or Attending Physister deeth. Objector: After this in by the funeral dispersion of the funeral dispersion.			ow Injury occurred	
tal or Attending P irs aftar deeth. Tal Ofrector: After t led in by the funer	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (St City or Town	treet and Number or Au n, State)	ural Route Number,
	29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place (Check only one) 2 Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred et the time, date and place (Check only one)	curred et the time, d	lete and placa, and due	to the cause(s)
To the Total Community of the Community	> Skellyn Amsel MD D163	347 2	29d. Date signed (Month	D O
10	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) SAMSEL M.D. 1000 CATHEDIXAL ST	BAL	MY MORE,	MD 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			



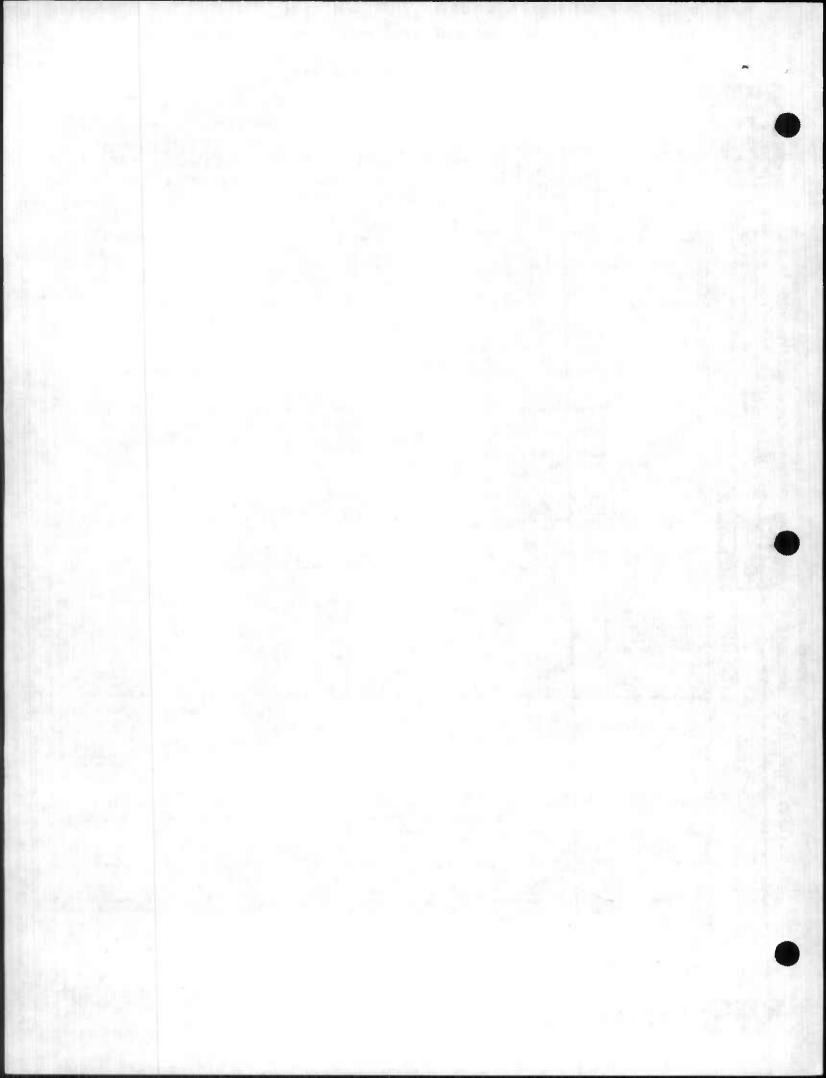
State of Maryland / Department of Health and Mental Hygiene

00 2490

		Certificate of Death	Reg. No.
		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physician	John George Mabus	Aug. 5, 2000 Year 4:30 pm
	/Medical		or Location of Death 4c. County of Death
-	Examiner		
I		1213 Oakwood Road Glen B	
	Funeral	1 M 2 F Months Days Hours M	Ain. (Month, Day, Year) Country)
	Director	215.10.9288	Aug.1,1910 Maryland
	P .	Usual Residence of Decedent	10d balds Challein
	abyon a	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	ot oto	MD Anne Arundel Glen Burnie	1 Yes 2 No
	with the Maryland ta or 28s-f show the notified at	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	3a o	1213 Oakwood Road 21061	U.S.A.
	ifter death with the Marylar r flems 23s or 28s-f show where must be notified at Funeral Director	11. Merital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	? (Specify Yes or No- 14. Rece - American Indian,
	the the	Armed Forces? If Yes, specify Cuban, Mexicen, Po	uerto Rican, etc.) Black, White, etc.
20		If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Yeer or Detes:	Specify: White
9	"natural",	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
21215-0020	ed within 72 ho ygiene. or then "natural, ft. fr. Wed call	(Specify only highest grade completed) (Give kind of work done during most of life, DO NOT use retired)	working
12	should be filed within nd Mental Hygiene. marked other than " imatic event, the the	Elementary/Secondary (0-12) Collega (1-4or 5+)	
	Co A Project	6 Woodcrafter	Carpenters Council Name (First, Middle, Maiden Sumame)
Ĕ	d off	17. Father's Name (First, Middle, Last) 18. Mothar's	Name (First, Middle, Malder Surfame)
1	Mental Mental arked of artic events To Be		ry Kenny
Maryland	2 sho end is me	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	r Rural Routa Number, City or Town, State, Zip Code)
-	ges 1 and 2 should be filed tof Heelth and Mental Hyg if Item 27 is marked other or other traumatic event, TO Be C	Pauline Mabus/Wife 1213 Oakwood Road	Glen Burnie, MD 21061
- P	of Health	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
E C	Pages nent of int: If It iny or o	TURBURIAL 2 Cremetion 3 Chemovel from State	0.40
altimore	교투원급.	Meddowl Idde Melli . FA	8/9 Elkridge, MD ary L. Kaufman Funeral Home
Ba	Depa Impo Impo Inca	N sal-years to	
			n Blvd. Elkridge, MD 21075
		23a. Part1. Entay the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cer shock, or beart failure. List only one cause on each line.	rdiac or respiratory arrast, Approximata Intarval Between
	Physician		Unset and Deeth
	/Medical	Immediate Cause (Final disease or condition rasulting in death) a. Gongestine Her	ent talino
	Examiner	rasulting in death) Due to (or as a consequence of):	
	<u>مِ</u>	5500 (5/ 45/2 50/1004/2 1/00 57/	
V	that the deeth certificate be assecuted ed by the attending physician and detached for use as the bunel-trensit Physician/Medical Examiner	b	
,	axac n an iel-tr	Sequentially list conditions, if any, laading to immadiate ceusa. Entar Underlying Cause (Disease or injury c	
68760	Sicia Burda		
8	entiticate be ling physicia a as the bu	rasulting in daath) Last Due to (or as a consequence of):	
×	nding Jse a	d.	
Bo	deeth of for u		1
o	bed bed	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobecco use contribute to the cause of death?
P.0	that the sed by the detache	Champe Live Miscare	1 Nos 2 No 3 Probably 4 Unknown
Ś	one de d	510101000000	
Records,	The law requires that the deeth or sete has been signed by the attend page 2 should be detached for us Completed by Physiciary	Dronge K- Implentation	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
8	sho sho	1. 1465 ward trullegrand	completion of ceuse of death?
Re	The law ste has begge 2 s		1 Yes 2 No
TO	C. Paris		
Vital	Physician: The law this certificate has ral director, page 2 To Be Comp.	axaminer?	Death (Check only ona)
5	5 00	1 Inpatient 2 Er/Outpatient 3 DOA 4 Nursin	ng Homa 5 Besidence 6 Other (Specify)
_	ng from	27. Manner of Death 1 Deatural 5 Panding (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division of	after deeth. Director: After Jin by the fune	2 Accident Investigation M 1 Yes 2 No	
Ξ	ier di ier d	3 ☐ Suicide 4 ☐ Homicida 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
0	tal or Attending P rs after deeth. al Director: After t led in by the funera Certification:		
	hou hou	29a. Certifier (Check only 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and p	
	To the Mospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred at the time, date and place, and dua to the causa(s)
	Neithir Nomp	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		CYIN MID GOOD SECOND	23 8/2/01
	0		0 3 0111-0
	10	30. Name and address of person who completed cause of death (flam 23a) (Type, Print)	Lieb of allung
		21 Date fied Month Day Vood	solvie 11ayour
1	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	21501

ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jeraldine Mickle 4b. City, Town, or Location of Death 3, 2000 4c. County of Death 4a Facility Neme (If not institution, give street and number) Baltimore H Under 1 Year If Under 24 Hrs. 8. Date Agnes Hosp, tal Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours 1 M 2 F Ma 217-20-1266 Yrs. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Md 1+imore 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A 21229 Indhurs 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 □ Yes 2K No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) School Elementery/Secondery (0-12) College (1-4or 5+) School Teacher 12-th grade 1aster Degre 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Williams Hice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) hristopher G Mickle-Son Rockbridge 7646 Elkridge, Md 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1) Burial 2 Cremation 3 Removal from State Ow.nas Forest Vet 8-9-00 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee West Wabash Balto, And ZIZIS 1300 Guenue 23a. Pent. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listoniy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) PROBABLE NEARCTION MYOCARDIAL 24-36 HAS Due to (or as a consequence of) THEROSCIENOTIC CANDIONASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence ot): Due to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MULTIFUCH CRUSIS. 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No 1 Pres 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Pinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work?

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Director

Framiner ment be or

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event page.

Saitimore, Maryland 21215-0020

by

Be Completed

Medical Certification: To

1 PNatural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signeture and title of certifier

war

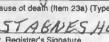
NAME (OSA BLDINE W. M. ICKLE Division of Vital Records. P.O. RAY or Attending after death. Diractor: To the Hospital of within 24 hours at To the Funeral D completely filled it

> State Registrar

DHMH 16 Rev 6/95

5 Pending investigation

6 Could not be determined



28e. Place of tnjury - At home, term, street, tectory, office building, etc. (Specify)

29c. License number

1 Yes 2 No

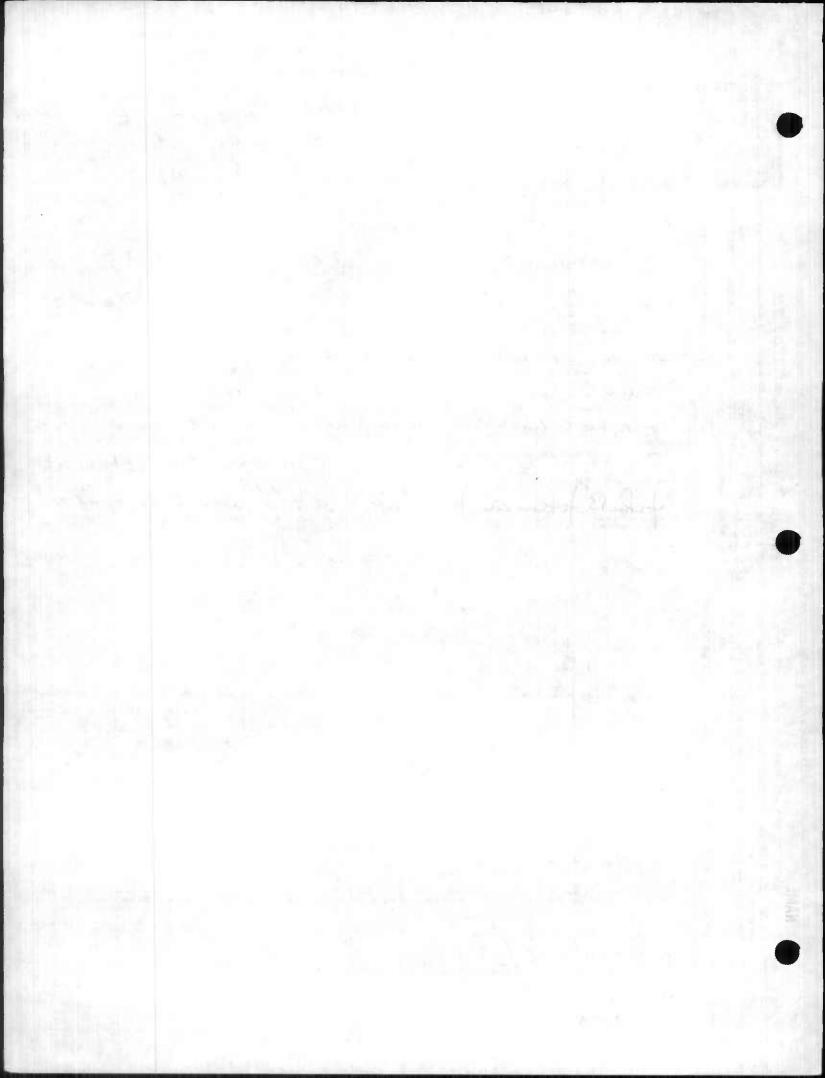
12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DELC MILHAEL E PEL 31. Dete filed (Month, Day, Year) STABNES HEALTHCARE GOOCATON AVE BALTO, MO 21229 32. Registrer's Signature

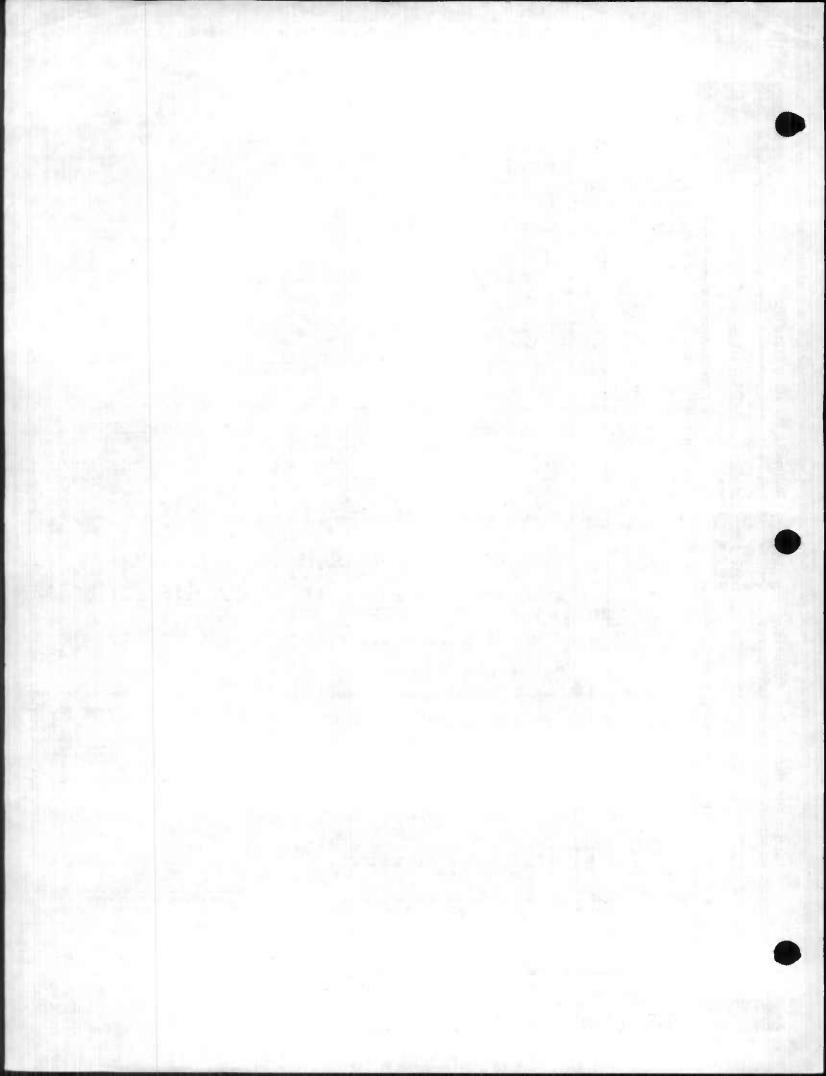
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State of Maryland / Department of Health and Mental Hygiene 00 21,005

_				Centificate	of Death		g. No.	
	Physician	1. Decedent's Nama (First, Middla, Last)		_		2. Data of Death Month	Day Yea	10
3	/Medical	DUNIVA J	MURPI-1		4b. City, Town, or t	AUG-UST	2NO 200	
	Examiner	4a Facility Nama (If not institution, giva					4c. County of De	atri
		Good Samaritan Ho 5. Social Security Number 6. Sax		st hirthday) If Undar 1	Baltimo		N/A	inhplaca (Stata or Foraign
	Funeral Director		M 2Å F 58	Months	Days Hours Min.	8. Data of Birth (Month, Day, April 2	6, 1942	Maryland
dond	No.	10a. Stata 10b. County	10c. City,	Town or Location				10d. Insida City Limits
AAar	ctor	Md. Anne Aru	ndel Li	inthicum				1 ☐ Yas 2 🕅 No
de de	or 28	10e. Street and Number		10f. Zip 6		10	g. Citizan of What (Country?
4	23.8	604 Highview Road			21090		U.S.A.	
22-0020	isi, or hams 23a or 28a-f show Examinat must be nonfied at by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	if Yas, speci	ant of Hispanic Origin? (Sify Cuban, Mexican, Puart	pecify Yas or No- o Rican, atc.)	Black, Wi	narican Indian, nita, atc. White
3 3	natural', adra Era	15. Decedent's Educ	cetion	16a. Decedant's Usual	Occupation	1	6b. Kind of Businas	
UZ00-C1212		(Specify only highest grade Elemantary/Secondary (0-12)	a complated) College (1-4or 5+)	(Giva kind of work lifa. DO NOT use	dona during most of wor a retired)	king		
1717 D	Hygiene. ther then and, the ten	12th	0	Homem	aker		Home	
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ar ylan	marked o	Delmas L. Jeete	r		Lois			
2 0	4	19a. Informant's Name/Ralationship (Ty)	oe, Print)		(Street and Number or Ru			
	Health Ham 27 other tr	Edward J. Murphy 20a, Mathod of Disposition	(Husband)	604 Highvi	ew Road Lint		aryland 2	
allimore	255	₩ Burlal 2 Cramation 3 □R	amoval from Stala	matary, cramatory or other	har placa)			
		4 Donation 5 Other (Specify)		Haven Mem	orial Park 8 Addrass of Facility	3/7/00 G	len Burni	e, Maryland
Dail.	Department Important: Pany injury o	21. Signatura of Funaral Sarvice License	L. Helton	McCully-	-Polyniak Fu Patapsco Ave	neral Ho	me,P.A.	vland 21225
Til political	hysician //Medical xaminer pauli Examiner	Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immediata ceuse. Entar Undarlying Cause, (Disaasa or injury	Dua to (or CONON)	as a consequance of):	201AL IN RTERY			YEARS
death cadificate be ex	phys s the	Causa (Disease or injury that initiated events rasulting in death) Last		as a consequanca of):				
1 100	00 -	Part II. Other significant conditions con	tributing to death but not rasul	iting in the underlying ca	usa givan in Part I.	23b. Did tol	pacco uae contribu	ite to the cause of death?
her the	Ph Ph	JUVENILE ONSE	T RHEVM	ATOID A	ARTHRITT.	∫ 1□ Ye	8 2 No 3	Probably 4 Unknown
Division: The law requires that the	ate has been signed to page 2 should be det	HYPOTHYROIDI	im, confac	ESTIVE 14	EART	24a. Was ar perform		b. Wara autopsy findings available prior to complation of causa of death?
- A	page Con	FAILURE, PL	MONARY M	IYPERTE	VSION	1□ Ya	s 2 PNo	1 ☐ Yas 2 ☑ No
Physician.	certificate rector, per	25. Was cesa ratarred to medical axaminar?	lospital:		Othor	ath (Check only one		
f	0 E 0	1 Yas 2 No	1 Lippatiant 2LIE	28b. Tima of Injury	A Vorian 4 Nursing F Bc. Injury at Work? 1 Yas 2 No	loma 5 ☐ Rasida 28d. Dascribe ho	nce 6 Othar (S) w injury occurred	pecify)
	2 2	1 Delatural 5 Panding						
Tanding the	death. ctor: After thi y the funeral floation:		28a. Place of Injury - At hor building, atc. (Specify)	ma, farm, straat, factory,	offica	281. Location (Str City or Town	reet and Number or , Stata)	Rural Routa Number,
TSION THE PORT OF	death. ctor: After thi y the funeral floation:	1 Natural 2 Accidant 3 Suicida 4 Homicida 29a. Cartifier 1 Certifying Physics	28a. Place of Injury - At hor building, afc. (Specify) lician: To the best of my knowner: On the basis of axemination and mannar stated.	riedga, daath occurred a	t tha tima, data and place	City or Town	, Stata) usa(s) and mannar	as stated.
TSION THE PORT OF	death. ctor: After thi y the funeral floation:	1 Natural 2 Accident 3 Suicida 4 Homicida 29a. Cartifier (Check only 2 Medical Examir	building, atc. (Specify) Ician: To the best of my knowner: On the basis of axamination	rledga, daath occurred a on and/or invastigation,	t tha tima, data and place	City or Town o, and due to the ca irred at the time, de	, Stata) usa(s) and mannar	as stated. dua to tha cause(s)
ISIOn	n 24 hours effer death. The Funeral Director: After this pletely filled in by the funeral edical Certification:	1 Natural 2 Accident 3 Suicida 4 Homicida 29a. Cartifier (Check only one) 29b. Signalura and tilla of certifiar	building, atc. (Specity) Ilcian: To tha best of my knowner: On tha basis of axamination and mannar stated.	rledga, daath occurred a on and/or invastigation,	it tha tima, data and place in my opinion, daath occu Licansa number	city or Town	usa(s) and mannar ita and place, and d	as stated. fua to tha cause(s) onth, Day, Year)
ISION	within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	1 Natural 2 Accident 3 Suicida 4 Homicida 29a. Cartifier (Check only one) 29b. Signalura and tilla of certifiar	building, atc. (Specity) Ilcian: To tha best of my knowner: On tha basis of axamination and mannar stated.	rledga, daath occurred a on and/or invastigation,	it tha tima, data and place in my opinion, daath occu Licansa number	city or Town	usa(s) and mannar ita and place, and d	as stated. Jua to tha cause(s)
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DHMH 16 Rev 6/95



Registrar

DHMH 16 Rev 6/95

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32. Registy

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Day Month **Physician** Edith M. Markwell 2100 4 2000 August /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Months Days 1□M 2☑F Yrs. June 11, 82 175-20-4366 1918 Pennsylvania Director Usual Residence of Decedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas XX No Directo MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 503 Harbor Drive 21403 USA Funeral filed within 72 hours after death Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedenf Ever in U,S. Armed Forcas? 14. Race - American Indian. "natural", or items 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 XXIVIO If Yas, Giva Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2XXNo Specify White à 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) than Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed with Dependentian of Health and Mental Hygien Important: if item 27 is marked other that any injury or other traumatic event, the page. Homemaker Own Home UNK 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Lydia Handwerk Algie Greene 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Routa Numbar, City or Town, Steta, Zip Code) Carol E. Gore (Daughter) 503 Harbor Drive, Annapolis, MD 21403 20b. Place of Disposition (Nama of cematary, crametory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2XX rametion 3 ☐ Ramoval from State AUG 7,2000 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Euneral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Intarval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical **Examiner** Examiner The law requires that the death certificate be asscuted Sequantially list conditions, if any, laeding to immadiata causa. Entar Underlying Causa (Disaase or Injury Ihal Inifialed events rasulting in daath) Last use as the buriel-tran Dua fo (or as a consequence of): ettending physicien and Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by emen þ 24b. Wara autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed?

pege 2 should be aftar death.

Director: After this certificata has I in by the funeral director, page 2.3 or Attanding Physician: To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

edical

Completed Be 25. Was case rafarred to medical Hospital: 10 1 Yas 2 No 28a. Data of Injury (Month, Day Yaar) Certification: 27. Mannar of Death 5 Pending Invastigation 1 Statural 2 ☐ Accidant 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, streaf, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a Cartifiar 29b. Signature and title of certifier

31. Data filed (Mo

29c. Licanse number Anngo

28c. Injury at Work?

1 Yas 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

1 🗆 Yas

28d. Dascribe how injury occurred

Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify)

26. Placa of Death (Check only ona)

28 No

1 ☐ Yes 2 ☐ No

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32. Regintrar's Signatura

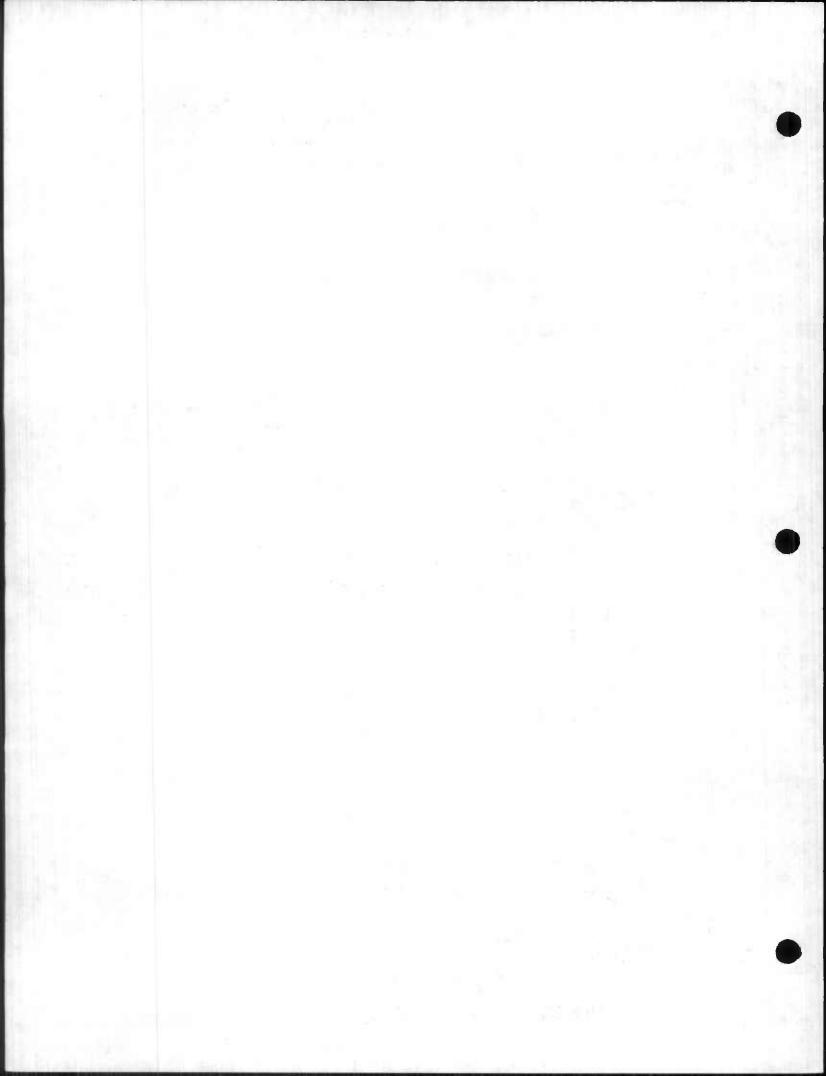
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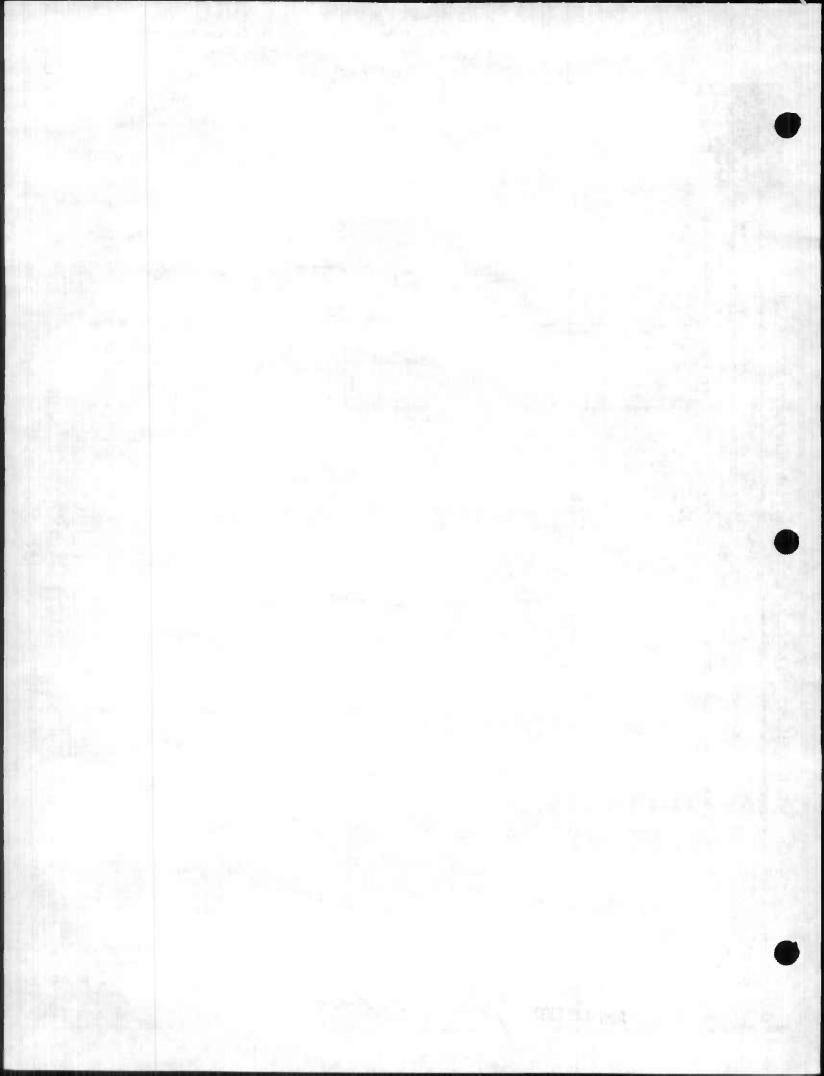
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State Registrar



State of Maryland / Department of Health and Mental Hygiene

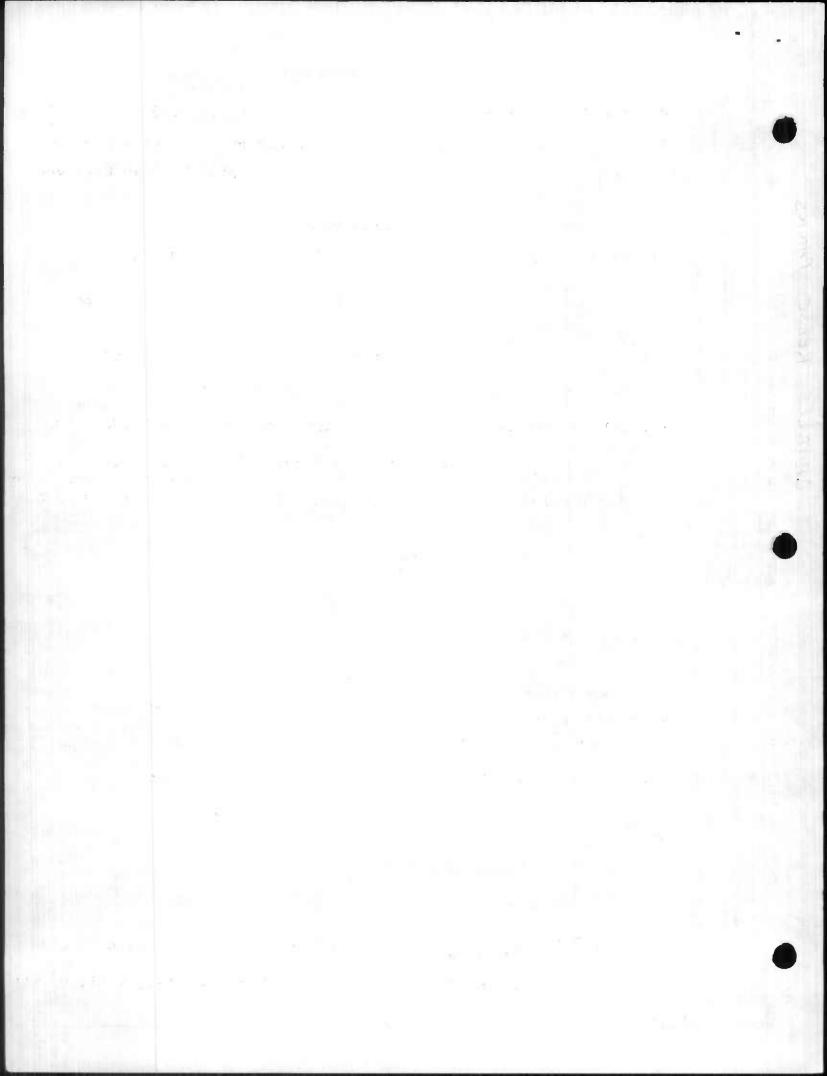
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Ruth F. Lutman - Daughter 121 Hastings Lane, Pasadena, MD 21122 20b. Method of Disposition (Neme of Disposition	d Med	19a Informant's Name/Relationship	(Type Print)	19h Mailin	on Address (Street	and Number or Ru	iral Route Number	City or Town, Ste	ate. Zip Code)				
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Registrar

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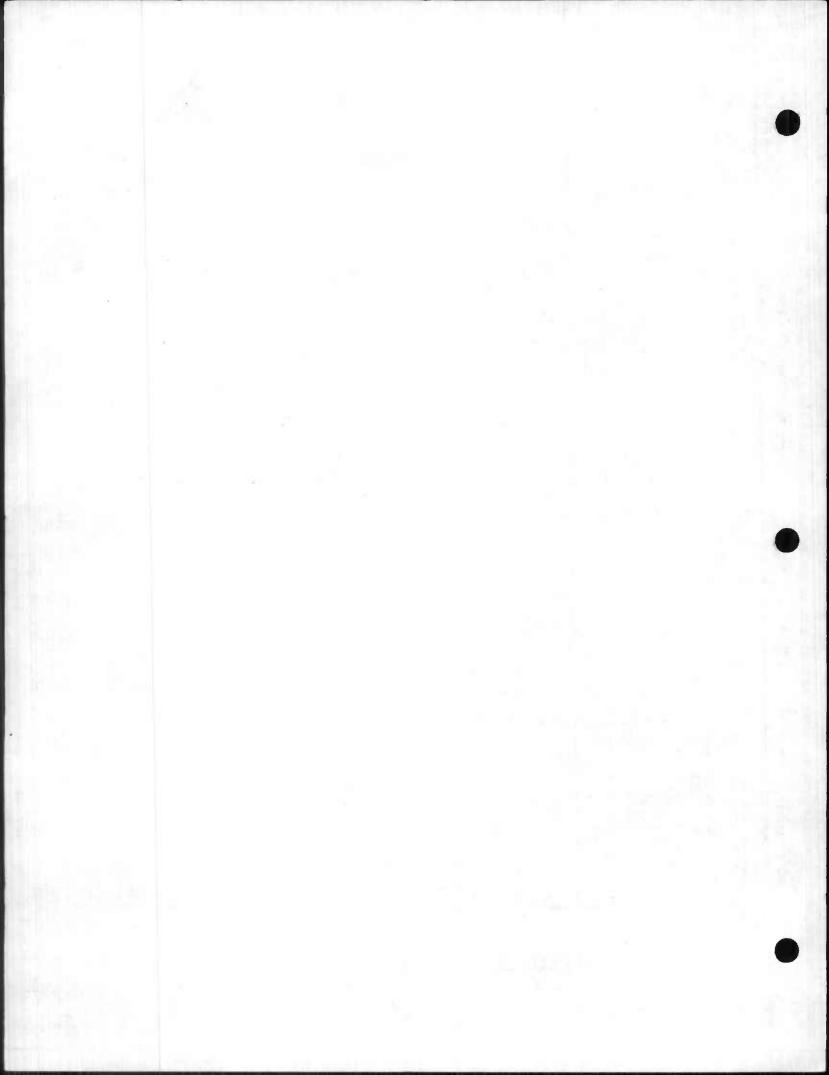
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State of Maryland / Department of Health and Mental Hygiene

	A 15.55						Cei	rtifica	te of i	Death			Reg. No.	00	24210
			1. Decedent's Name (First, Middle	, Last)								2. Data of De		Year	3. Time of Death
	Physicia	_	Julia L. Page									Month August	Day 2	2000	7:35 PM
	/Medic Examin		4a Facility Name (If not institution,	give street and	number)				4	6b. City, To	wn, or Lo	ocation of Death		ounty of Death	
	Examin	-1	Crofton Conval	esence	Cente	r				Crof	ton		1	Anne Ar	undel
-	Funanal			6. Sex		(In yrs. last birt	hday)	If Unde	r 1 Year	If Under		8. Date of Birt			
п	Funeral Director		219.07.1063	1□ M 2XX			Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, De 12/14/	y, Year)		place (State or Foreign intry) Vland
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<u>a</u>	Mental Mental Mental Mental Mental	0	Henry Burgan						4	Mar	y Ph	illips			
Maryland	# DEE		19a. Informant's Name/Relationsh	ip (Type, Print)		196.	Meitir	ng Addres	s (Street	and Numbe	er or Aur	al Route Numb	er, City or T	own, State, Z	ip Coda)
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ē,	~ f 5 5	-	20a. Method of Disposition			20b. Place of	Dispo	sition (Ne	me of		1	Date		tion - City or T	
9	Pages nent of mt: If he iry or o		1 Buriel 2 Cremation		m State	Bayvi		natory or			t	8/7	Pal+	· i mana	MD
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39	permit. Pages Department or Important: If I eny Injury or page.		21. Signature of Europai Service I	Zill /	1	4				ss of Facilit		NK FUNE			
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rt.	/Medical		Immediate Cause (Final disease or condition	6	to	interte		1.	Por	ling					1 day
	Examiner		resulting in death)	a		Due to (or as a c		~		eng				1	1444
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o.	the de	78	Part II. Other significant condition	s contributing to	death but	not resulting in	the u	nderlying	cause giv	en in Part I		23b. Did	tobacco us	e contribute	to the cause of death?
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Record	been sign ahould be	ě											an autopsy med?	8	Vere autopsy findings vailable prior to
O O	has by	Completed												0	ompletion of cause I death?
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VItal	certificate rector, pag	-	25. Was cese referred to medical							26. Place	of Deat	h (Check only o	one)		
		0	examiner? 1 Yes 2 3 No	Hospital:	Inpatien	i 2□ER/Out	nation	nt 3 D	OA Oth	er		me 5 Resi		Other /Spec	ifv)
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5	After After		1 Natural 5 Pending 2 Accident investiga		onth, Day	Year) Ir	njury	М		k? Yes 2□	No				
S	Attending it death.	2	3 Suicide 6 Could no	ot be	ce of Injur	y - At home, le	m str	eat lactor	v office			28f. Location /	Street and I	Number or Ru	ral Route Number,
Division	or Attendation of Director:	Certification:	4 Homicide determin	bui	lding, etc.	(Specify)	.,, .,,,	001, 180101	y, ooo		21	City or To	vn, State)		
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	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the	edica		Physician: To to xaminer: On the	basis of e	xamination end	or inv	occurred estigation	et the tin	ne, date en pinion, des	u place, th occur	and due to the red at the time,	cause(s) ar date and pt	laca, and due	stated. to the cause(s)
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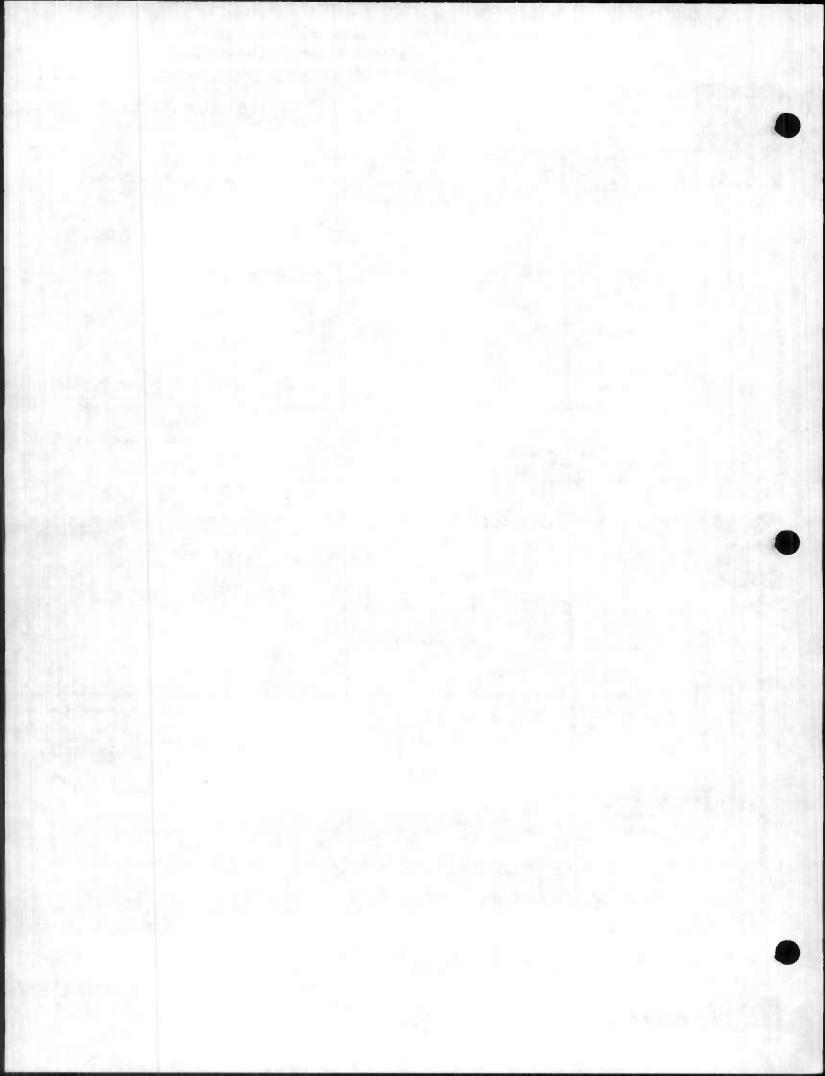
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

					Cel	uncate	OIL	Death			Reg. No.	00	the man	21		
D1	1. Decedent'a Na	me (First, Middle	, Last)	-						2. Date of De Month	eeth Day	Year	3. T	ime of De	eath	
Physician /Medical	LEONI	RD 1	ZEICH							AUGU		2000) 1	1:20	P	
Examiner	4a Facility Name Good Sa	(If not institution, maritan	give street and numb Hospital	ier)				b. City. To Balti		ocation of Dea	th 4c. Co	unty of Deal	th			
Funeral Director	5. Sociel Security	3366	6. Sex 7 1⊠ M 2□ F	Age (In yrs. last	birthday) Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Dec 6,			thplace (sountry)		ore	
3	Usual Residenca 10e. State	of Decedent		10c. City, T	own or Lo	cation							10d. Ins	ide Clty	Lim	
of a Po	E 1200	Baltin	more	Carn									10	Yes 2	Ð	
or 28a-f s be noutred Director	10e. Street and N	lumber			- 3	10f. Zip (Code				10g. Citizen	of What Co	ountry?			
23a or	2802 Sec	cond Ave				2123	4				USA					
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ted bet	/90	15. Decedent	s Education t grade completed)	1	6a. Deced	dent's Usual	Occupa	ation	t of work	ina	,		iness/Industry			
Hygiene. ther than "natural", or flems 23a or 28a-f show and, the Medical Examinar must be notified at any or Completed by Funeral Director	Elementery/Se		College (1-4		Engin	kind of work DO NOT use 1eer	retired)	i oi work	n ry	Weste	rn El	ectr.	ic		
B & W	17. Father's Nam	e (First, Middle, L Leich	ast)							ne (First, Middle, Maiden Sumeme)						
0 E E		Name/Relationsh . Reich	ip (Type, Print)							ey, MD		own, State,	Zip Code,			
Department of Heelth Important: If Nem 27 any Injury or other tr ance			3 □Removal from St	ate cem	etery, cren	osition (Name matory or off ral Cha	er plec		r	Date Aug 8		ion - City or t Hil				
Departri Importa any Inju	21. Signature of	Eutheral Service L	censee (1.)	De	1	Name and Evans 8800 H	Fun	eral	Chap		lle. M	ID				
inding physician and use as the burial-transit	diseese or condi resulting in death Sequentielly list if any, leading to cause. Enter Un Cause (Disease that initieted ever resulting in death	conditions, immediate derlying or injury		Due to (or as	s a consequence a consequence	quence of): ART quenca of):				EASE						
ing physicie se es the bu		Part II. Other significant conditions contributing to death but not resulting in the un							underlying cause given in Part I. 23b. I					id tobacco use contribute to the cause of de		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24912 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Juanita Booker Mathews Roane 4b. City, Town, or Location of Death 1, 2000 4c. County of Death 2:10 AM 4a Facility Name (If not institution, giva street and number) Greater Baltimore Medical Center Baltimore Baltimore if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1□ M 25 F 231-54-1520 Nov. 2, 1943 Richmond, VA Usual Residence of Decedent Anne Arundel 10c. City, Town or Location Odenton 10d. Inside City Limits 10a. State Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 192 Langdon Farm Circle 21113 U,S,A, 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Never Married 2 Married Black 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elamantary/Secondary (0-12) years Teacher Private 18. Mother's Name (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Daniel Webster Booker Doris Brooks Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) David A. Roane Husband 192 Langden Farm Circle, Odenton MD, 21113 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata 20a. Method of Disposition Cametary, cramatory or other place) Uakwood temetery N☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 8/5/00 Richmond, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave., NW, Wash., DC CC0348 20011 mile 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sauce on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Len Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No HOS 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Panding 2 No Investigation 1 Yes

Examiner Tuanta

To the Hospital within 24 hours a To the Funeral L

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show the Medical Examiner than be notified at

then

marked

important of Health and Important if Item 27 is ma any injury or other transportant.

Physician

/Medical

Examiner

Physician/Medical

þ

Be Completed

Medical Certification: To

Funeral Director

à

Completed

with the Maryland

filed within 72 hours after

Pages 1 and 2 should be next of Health and Mental

Maryland 21215-0020

Baltimore,

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

3 Suicide

29a Certitier

4 Homicida

29b. Signature and Ifficial of on

32. Registrar's Signature

N. Charles St. Balto

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street and Number or Rural Route Number, City or Town, Stata)

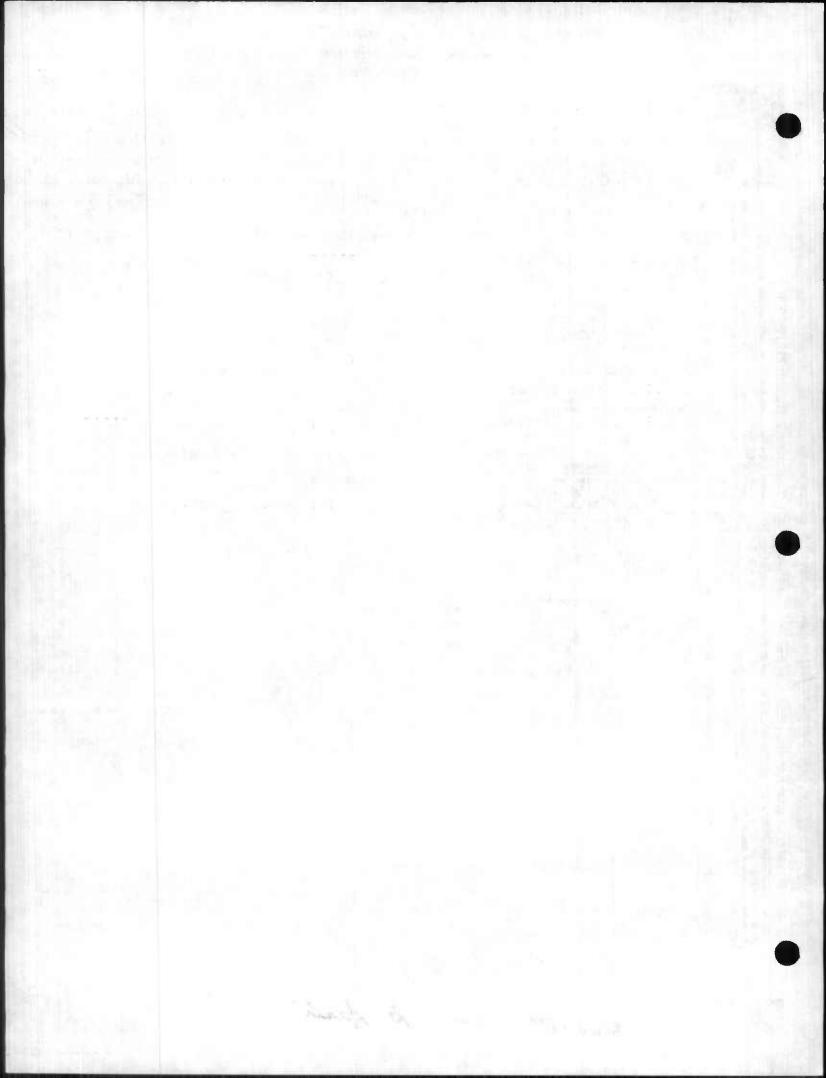
AUG 0 8 2000

6 Could not be

My

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

of death (itam 239 (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dey **Physician** 6, 2000 4c. County of Deeth Ryer Aug /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner 7862 Bodkin View Drive Pasadena Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min 1□ M 21 F Yrs. Director 83 216-03-3474 July 16,1917 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location

10:40 A.M Birthplace (State or Foreign Country) Maryland the Maryland 10d. Inside City Limits than "natural", or flems 23s or 28s-f show 7 is marked other than "natural", or itema 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 M Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2516 Washington Blvd. 21230 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 9 N/A Housewife Own Home permit. Pages 1 and 2 should be file Department of Haalin and Mental Hyg Important: If Item 27 is marked any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be John Schack Neubert Olga 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7862 Bodkin View Drive Pasadena, Maryland 21122 Joan E. Popa (Daughter) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/10/00 Brooklyn Park, Md Cedar Hill Cemetery 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last usa as the bunal-tran Due to (or as e consequence of): ed by the attending physician and deteched for use as the bunet-rer P.O. Box 68760. Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tata has been signed by paga 2 should be datach Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed this certificate has 1 🗆 Yes 1 Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Bother (Specify) Daughters 1 Yes 2 No 10

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

Hospitel: 1 | Inpatient 2 | ER/Outpalient 3 | DOA 5 Pending Investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

27. Manner of Deeth

1 Netural

2 Accident 3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifie

6 Could not be determined

29c. License number

and address of person who completed cause of death (Hem 23e) (Type, Print) 30. Name

te filed (Month, Dey, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral

Certification:

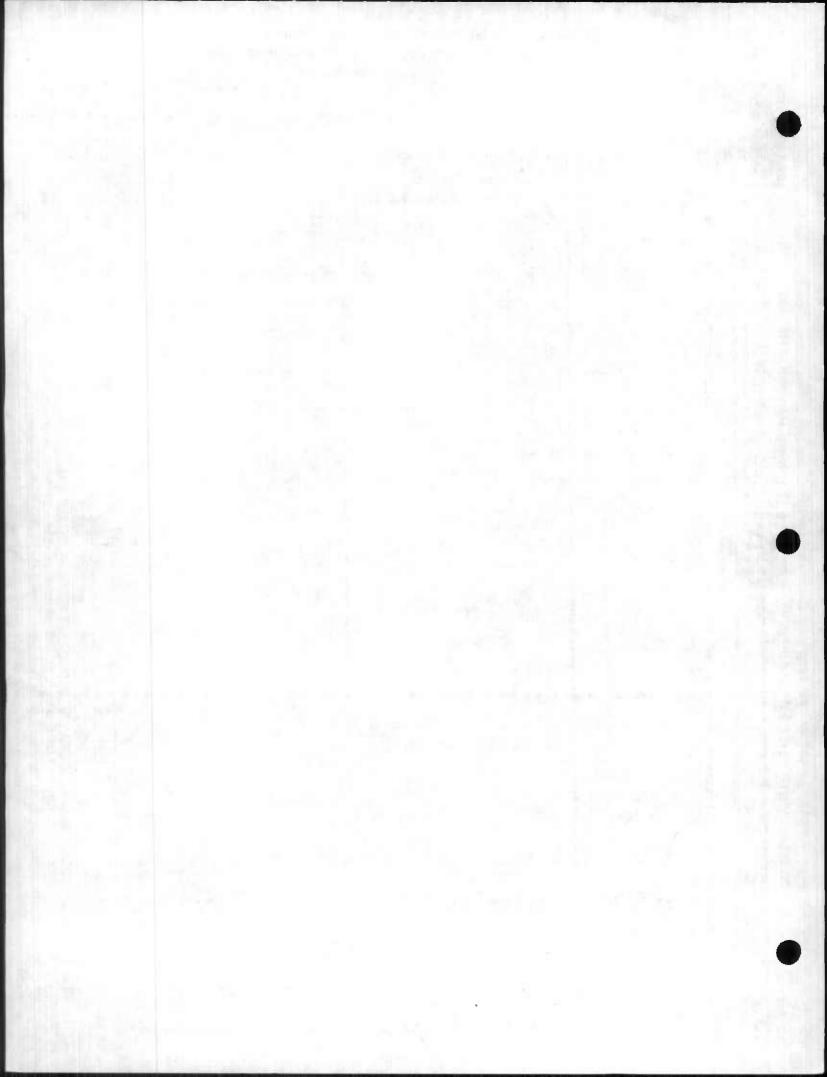
Medicai

m. J

State Registrar

Residence

29d, Date signed (Month, Day, Year)



State	of	Maryla	and /	Dep	artmer	nt of	Heal	th and	Mental	Hygien
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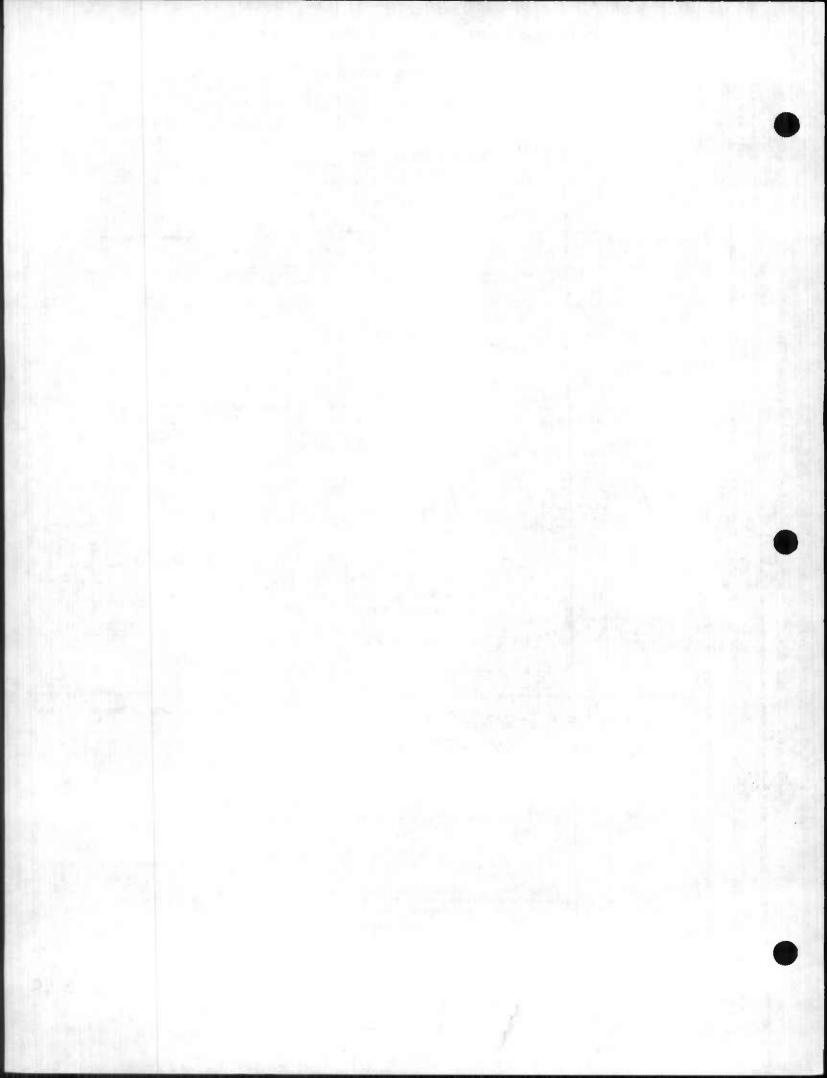
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			Lillie	M R	idgway				6 Day 2000	Year	3:15a
ledical aminer	4a Facility Name	(If not institution,	, giva street and numb	oer)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
	805	Platin	am Ave.			Total L	Essex		Ba1	Ltimo	re
eral ctor	5. Social Security 214–20–		6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. I		If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 2	Year) 25,1921	9. Birthp Coun MA.r.	laca (State or Fo try) yland
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Direc	10e. Street and No	umber Platinur	n Ave.			10f. Zip Code 21	221		0g. Citizen of V	Vhat Coun	try?
by Funeral Director	11. Marital Status 1 Never Mar 3 Widowed	rried 35 Marrie	12. Was Decede Armed Force at 1 Yes 2 If Yes, Give Year or Date	as? ☑ No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
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E O	Elementery/Sec		College (1-4	Or 5+)	Stock	Clerk			Marti	in Ma	rietta
To Be C	17. Father's Name						18. Mother's Nam unkn		Maiden Surnam	10)	
or other traumatic event, the land	19a. Informant's N		nip (Type, Print) husband				and Number or Run			_	Code)
OED	20a. Method of Di			20b. P	lace of Dispo	sition (Name of	an)	Date	20c. Location -	City or To	wn, Stete
once.		2 ☐ Cremation 5 ☐ Other (Sp	3 Removal from Sta	are		matory or other pla	- 1-	/2000	Baltimo	ore M	ID
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niner niner	resulting in death))	- AR	Dua to (or	as a conse	quence ot):	Trette	ert D	ic . ac	20 1	0 420
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DHMH 16 Rev 6/95

Registrar

AUGUST 6 2000

Lillie Ridgeway



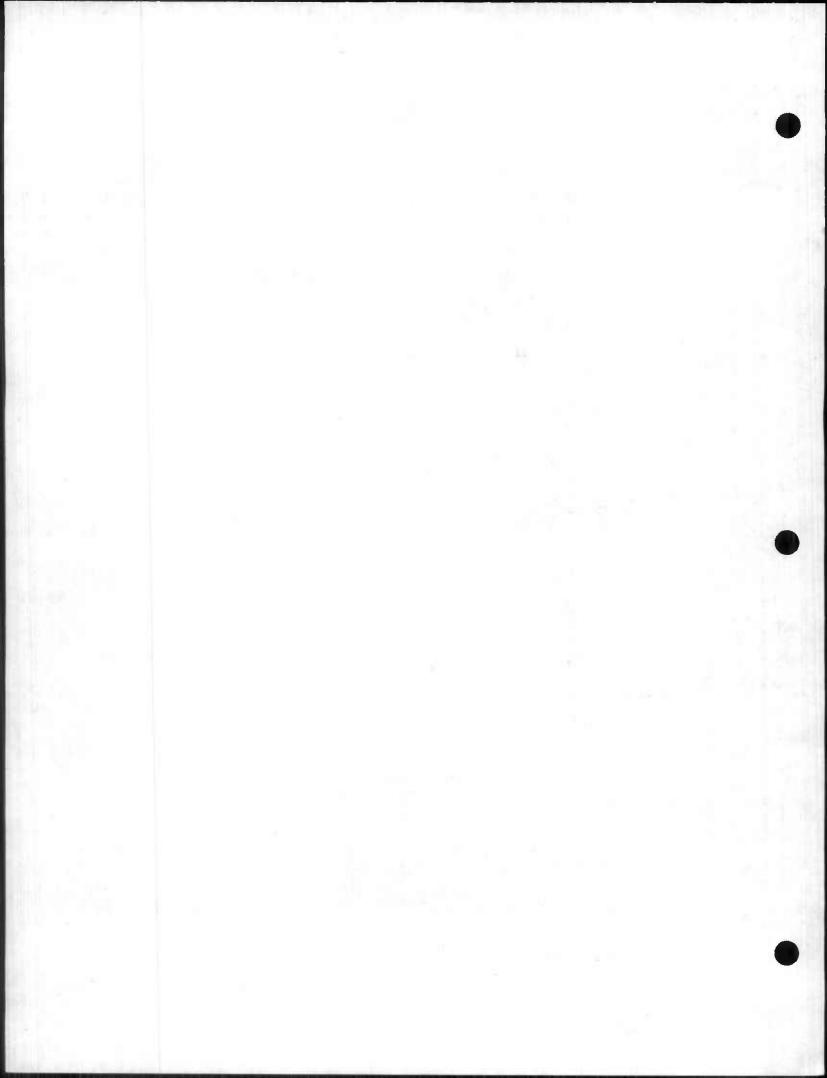
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State of Maryland / Department of Health and Mental Hygiene

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Allended Ite	11 1/ 23C per ME 6/00 6-	0-00 w]]		Certii	ricate of	Death			Reg. No.			
Physician /Medical	1. Decedent's Name (First, Middle, L	Ryan				4b Ciby To		2. Dete of De Month AUGUST cation of Deat	Day 03,200		3. Time of Death 10:13 P.M	
Examiner	4a Facility Name (If not institution, g E/B SUITLAND PKW)		UITLAND			SUITI	AND		PRINCE GEORGE'S		ORGE'S	
Funeral . Director	5. Social Security Number 6. 190-66-2475 Usuel Residence of Decedent	Sex 1 I M 2 □ F	e (In yrs. last birt 29	N	f Under 1 Year fonths Deys	If Under: Hours	Min.	6. Date of Bir (Month, Da)ct. 24	th y, Year) 1,1970	9. Birthple Count New	Jersey	
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or 28a-f a be notified Directo	10e. Street and Number				10f. Zip Code				Vhet Count	ry?		
23a o unit be	1156 Lake Ridg	ne Drive				2068	9		USA			
Maryland 21215-0020 3 2 should be flied within 72 hours after death with and Mantal Hoggere. The marked other than "natural", or thems 23s traumstic event, the Medical Examiner must traumstic event, the Medical Examiner must to the Completed by Funeral	11. Meritel Status 1 Never Merried 2 Married	12. Was Decedent I Armed Forces?	Ever in U,S. 10		s Decedent of Hes, specify Cub	Hispenic Ori en, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	14. Rac Bled Specify	in Indien, itc. te		
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/lan	Joseph Ryar	1					Isab					
View Park	19e. Informent's Name/Reletionship								er, City or Town,			
N September 277	Melanie Ryan - W			1156	Lake R	idge D	rive	, Sund	689			
	20e. Method of Disposition		20b. Place of	b. Place of Disposition (Name of cemetery, crematory or other place)				Dete	20c. Location	City or Tov	vn, Stete	
Limore Pages 1 a ment of He tent: If leen dury or othe	1 Buriel 2 Cremetion 3					ice)	iA.		Poncal	om D	۸	
E	4 Donetion 5 Other (Spec		Resur		100 ame and Addre	see of Facilit		ig. 9	Bensal		ome, P.A.	
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death death e atter ad for u	Pert II. Other significant conditions	contribution to death by	ut not resulting in	the unde	erlying ceuse gi	ven in Pert I	-	23b. Did	tobacco use co	ntribute to	the cause of death?	
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Ctoto	30. Neme and address of person who Stephen S. 31. Date filed (Month, Day, Year)	Radent		1	11 Penn		et, E	Baltimo	ore, Mar	yland	21201	
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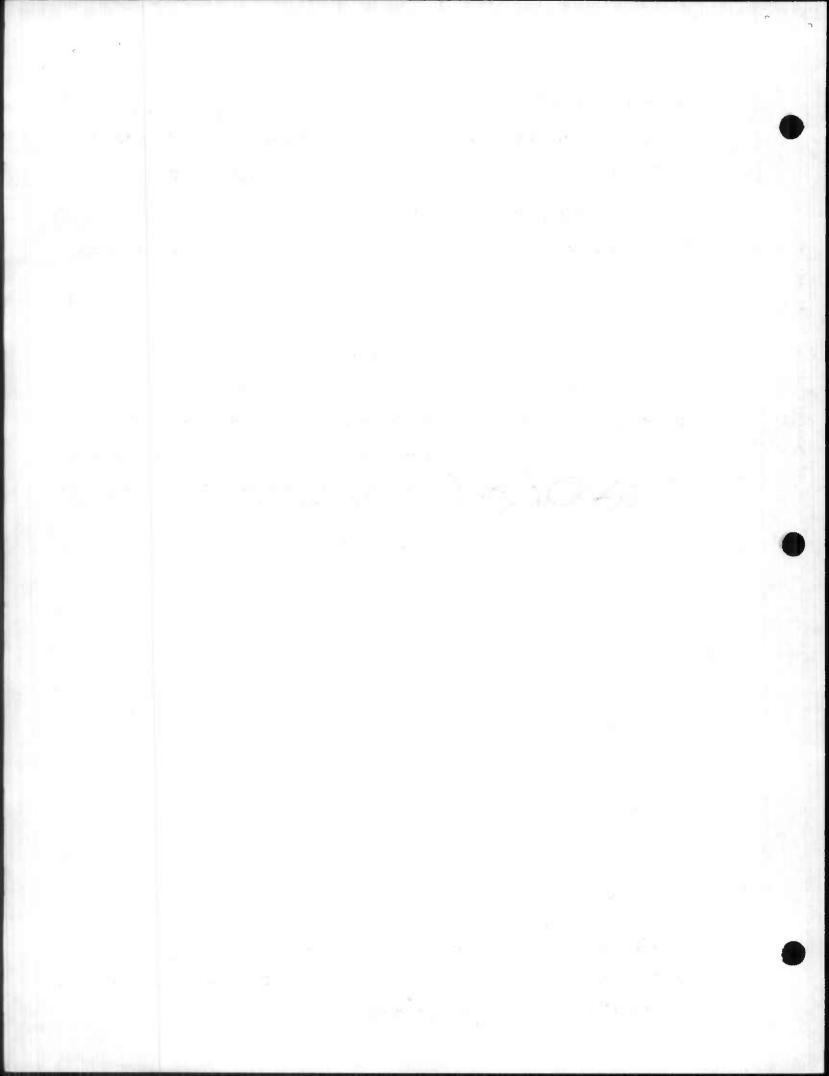
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 00 24917

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Smith helma 2000 OCAM /Medical 4c. County of Death 4a Facility Neme (If not institution, give atreet and number) **Examiner** 6. Sex 10MNS HOPKENS ORK 5. Social Security Number 9. Birth (In yrs. last birthday) (State or Foreign **Funeral** Days 10M 20F 215-30-0623 Director Usual Residence of Decedent with the Meryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director MORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 100 death Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "netural", or items 11. Meritel Stetus filed within 72 hours eher Yes 2 No f Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 21 No Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mentel Pages 1 and 2 should be pue 19a. fnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) -Department of Health elimportant: if Item 27 la any Injury or other trainings. 2/222 LOOK GATE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete AUG.4 Buriel 2 Cremetion 3 Removel from Stete □ Donetion 5 □ Other (Specify) 2000 21. Signature of Fameral Service Licensee 23e. Pert1. Enter the disease, or complications that caused the eeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. Est only one cause on each line. Approximete Intervel Between Onset and Death

Physician /Medical Examiner

The lew requires that the death certificate be executed

68760

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Division of Vital Records,

i or Attending Physicien: The lew require ahar death. Director: Aher this certificate has been si d in by the funeral director, page 2 should I

filled in by

To the Hospital within 24 hours a To the Funeral C

Physician/Medical Examiner

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Be Completed

Medical Certification: To

Baltimore, Maryland 21215-0020

Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Finel disease or condition resulting in deeth)

Myocardia Due to (or es e consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 2 No

2 hours

26. Place of Death (Check only one)

1 Yes 2□ No

25. Was case referred to medical 1 Yes 2 No 27. Menner of Death

5 Pending investigation

28e. Plece of Injury - At home, ferm, street, lactory, office building, etc. (Specify)

1 MInpatient 2 □ ER/Outpatient 3 □ DOA

Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Cartifier

1 Netural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end manner stated.

29b. Signature and title of certified - MD

6 Could not be determined

29c. License number RES-000 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Tower 110, 600 North Wolfe Street, Baltimore, Maybord 21287 Mohammed Khan, Johns Hopkins Hospital, 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

AUG 0 8 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Billy Stone AUGUST 6, 2000 8:45 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Days Hours Min 1⊠M 2□ F 213-07-7080 82 Yrs. Director Aug 17, Maryland Hsuai Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. inside City Limits 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Funeral Director MD Baltimore Parkville 10g. Citizan of What Country? 10f. Zip Code 10e Street and Number 21234 USA 8618 Richmond Ave. or items 23a 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel". White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry U.S. Government then Elementery/Secondary (0-12) College (1-4or 5+) Electrician other 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 end 2 should be nent of Health and Mental if of Health and Mental Stone Ruby Morheiser Daniel 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8618 Richmond Ave., Parkville, MD 21234 Nannette Stone 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State Dete 20a. Method of Disposition Aug 2000 0 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata Parkville, MD Moreland Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Address of Facility Evans Funeral Chapel 8800 Harford Rd. Pa Parkville, 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Betw Onsat and Death **Physician** immediate Cause (Final diseese or condition resulting in deeth) /Medical PNEUMONIA - BACTERIAL 3 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Lasf Due to (or as a consequence of): burial-trar Box 68760, Due to (or as a consequence of) use as the P.0. detached Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an eutopsy LUNG CANCER page 2 1 ☐ Yes 2 No 1 Yes Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death

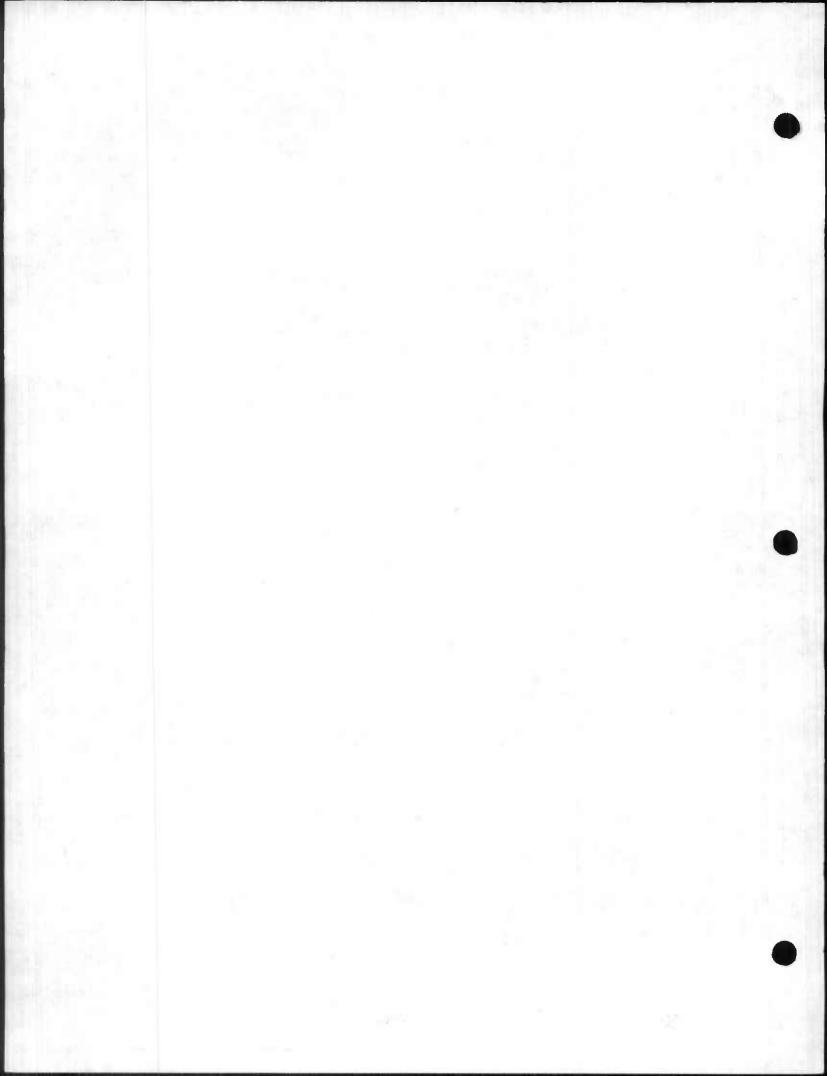
1 Natural

2 Accident 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation after death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, streef, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a To the Funerel C Descripting Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and mannar as stated.

| Continued in the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely To the 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier 0 AUGUST 6, 2000 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) PENELOPE SCOTT, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State oaks AUG 0 8 2000

DHMH 16 Rev 6/95

Registrar



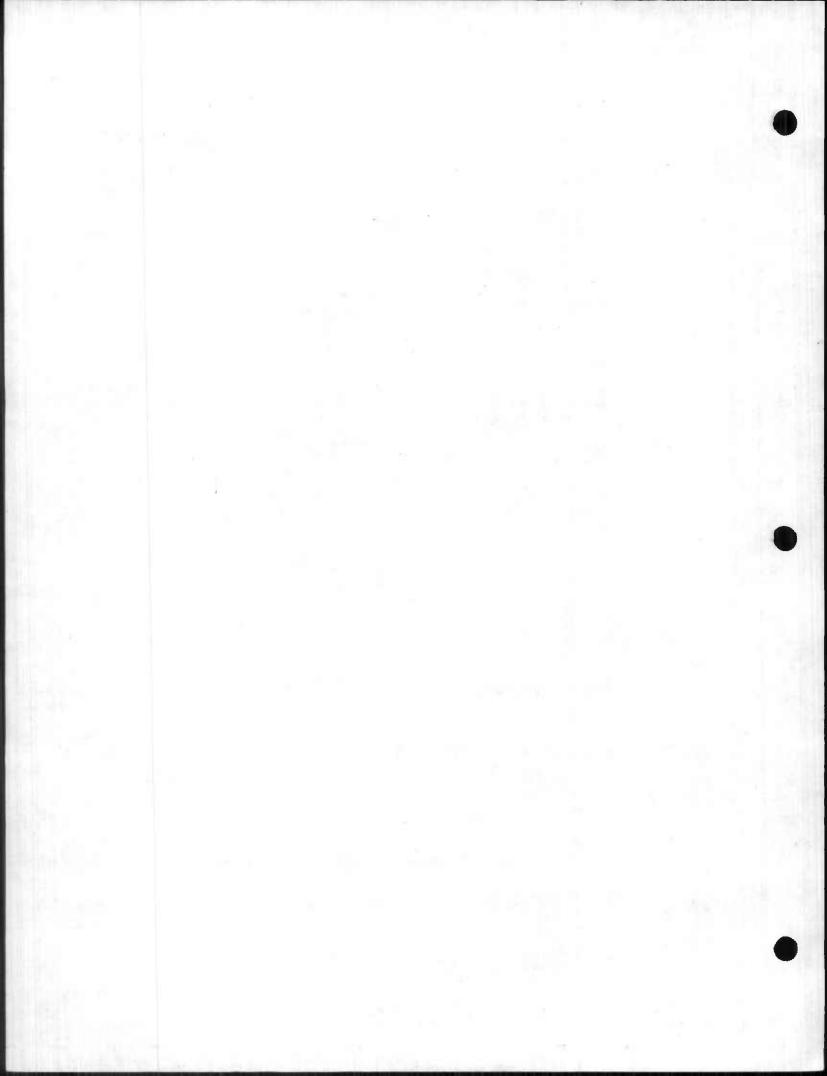
						Cei	rtificat	e or	Death			Reg. No.	U	24920
	Physici /Medi		Decedent's Name (First, Middle, LIDYA	ast)		SVII	SKAYA	A		7	2. Data of De Month UGUST	5, Day 2000	Year	3. Tima of Death 11:42 AM
	Exami		4a Facility Nama (If not institution, gi NORTHWEST HOSP)						4b. City, To		cation of Deat		of Death	E
	Funeral Director		220-39-9136	Sex 1□M 2IXF	7. Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days		24 Hrs. Min,	8. Date of Bir (Month, Da JUL.19		9. Birthp Cour	blace (State or Foreign offy) UKRAINE
	Maryland a-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	ORE	10c. C	ity, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ath with the Marylan 23a or 28a-f ahow LEL De notflind at	ai Director	10e. Street and Number 1450 BEDFORD A	VENUE #	417		10f. Zip	Code	2120	8		10g. Citizen of V U.S.		ntry?
020	after day	by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed F	2 No		Was Deced if Yes, spec			gin? (Spe i, Puerto F	cify Yes or No lican, etc.)	Specify	ck, White,	en Indian, etc. WHITE
Maryland 21215-0020	within 72 hours and and "natural", or Wassell English	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed	(1-4or 5+)	16a. Dece (Give life. HOME)	kind of wo DO NOT us	rk done	during most	t of workin	og .	16b. Kind of B		dustry
7	77 60 5		17. Father's Name (First, Middle, Las			HOME	MINER		18 Mothe	r's Name	/First Middle	Maiden Suman		
and	S is b >	Be		'/					- 14		(First, Middle			777777
7	2 should be and Menta la marked aumatic ev	10	ESSAK			SVIDSKA			SARR	_				SKAYA
Jai	2 sho		19a. Informant's Name/Relationship		* 1.7m							er, City or Town,		
	f Haaith fem 27 other tr		GRIGORIY KOGAN	/ HUSB					AVENU	E #4.		ALTIMORE		
Baltimore,	Pages nant of ant: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	ity)	State	Place of Dispo cemetery, crea LTIMORI	natory or o	ther pla		ERY 8	Date 3/7/00	20c. Location -		
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x 68760,	Physician /Medical be expended dup / Medical Examine and physician and physician and physician are as the portal fransit	VMedical Examiner	Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	bd_	Due to	ple of as a consector as a consector as a consector	juence of):	esc	ma					
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, P.O.	that the ed by th datache	by Physician	Part II. Other significant conditions	contributing to (death but not re	sulling in the u	nderlying c	ause gr	ven in Part I			Yes 2 No		the cause of death? bably 4 Unknown
ecords,	s been 2 shoul	Completed b										an autopsy omned?	av	ere autopsy findings ailable prior to implation of causa death?
Œ	0 5 2	EO									10	Yes 2 No	11	☐ Yes 2☐ No
Vital	certificata rector, pag	Bec	25. Was case referred to medical						26. Place	of Death	(Check only	one)		
>	Physician: this certific ral director,	ToB	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	Ot	her			dence 6 Oth	er (Sneci	61
ion of	of the series		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date (Mo		28b. Time of Injury		8c. tnju Wo	ry et rk? Yes 2	2		how injury occur		,,
Division	filer of Minect	Certification:	3 Suicide 6 Could not to determined	288. Plac	e of Injury - At h	iome, farm, str	eet, factory	, office		2	8f. Location (City or To		er or Run	al Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completaly filled in by	edical	29a. Certifier 12 Certifying Pl (Check only one) 2 Medical Example 12	miner: On the I	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	occurred restigation,	at the ti	me, date an opinion, dea	d place, a th occurre	nd due to the id at the time,	cause(s) and madate and place,	anner as s and due t	stated. to the cause(s)
	To the Compi	2	29b. Signatura and little of certifier				290	Licens	se number			29d. Date signe	d (Month,	Day, Year)
	of) COYE	OD			1	Da	355	45	9	Augi	uot?	1,2000
	W.	1	30. Nama and address of person who	nanh	(Ch)		Print)					0		

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State of Maryland / Department of Health and Mental Hygiene

Registrar

AUG 0 8 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death IVAN SOROKOPUN Year 8:0496 AUGUST 200 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours M 2DF 77 219-92-7889 Yrs JUL.30,1923 UKRATNE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 PARK HEIGHTS AVENUE #902 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced Yeer or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MECHANIC AUTOMOBILE 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) SOROKOPUD MICHAEL ANNA **FEDEROV** 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5715 PARK HEIGHTS AVENUE #902 - BALTIMORE, MD 21215 DORA SOROKOPUD / WIFE 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) HILLTOP SERVICE CORP. B/7/00 TOWSON, MD 21. Signature of Funeral Service Licen 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Immediate Cause (Finel disease or condition resulting in death) onsequence of): Cell Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of seath? 1 Yes 2 No 3 Probably 4 Unknown Kenal Failer D 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No 1 Yes 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

the death certificate be axecu

Box 68760,

P.O.

Records.

Division of Vital

Hospital

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

iral", or Itams 23s or 28s-f show Examiner must be notified at

"natural", or Itams 23a

Pages 1 and 2 should be filed within 72 hours after a nant of Haulth and Mental thyslene.

Art: If Nam 27 Is marked other than "natural", or has my or other traumatic avent, The Model Traumatic avent, The Model Traumatic Avent, The Model

Department

Baltimore, Maryland 21215-0020

Director

Funeral

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Examiner Physician/Medical Completed by Be

siclan end burial-transit physiclan s the burial use signed t certificate or Attanding Physician: Certification: To this After 24 hours after deeth. 3 filled in

Medical To the Hosp within 24 hor To the Fune completely fi V State Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

1 | Inpatient 28a. Dete of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture and fille of

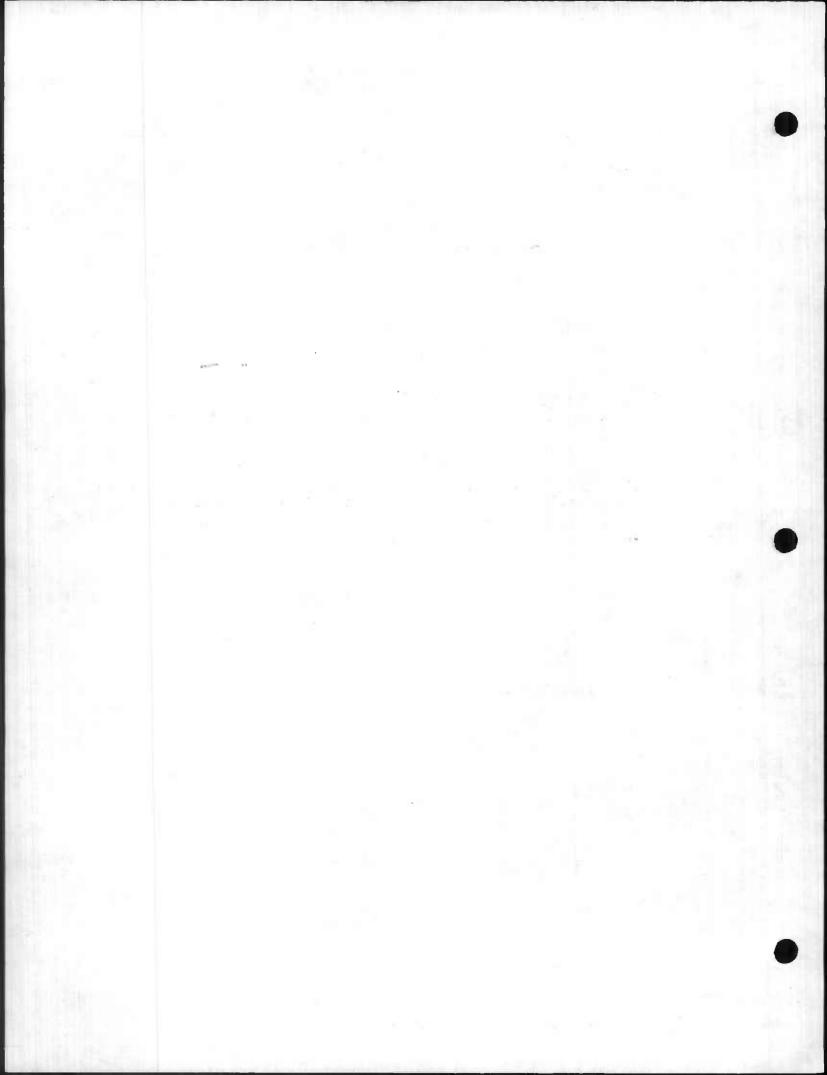
29c. License number

29d. Date signed (Month, Day, Year) 200 5

30. Neme end addre ited cause of death (Item 23e) (Type, Print) INTPERINT

31. Dete filed /Ma th, Day, Year) 32. Registrer's Signeture oaks

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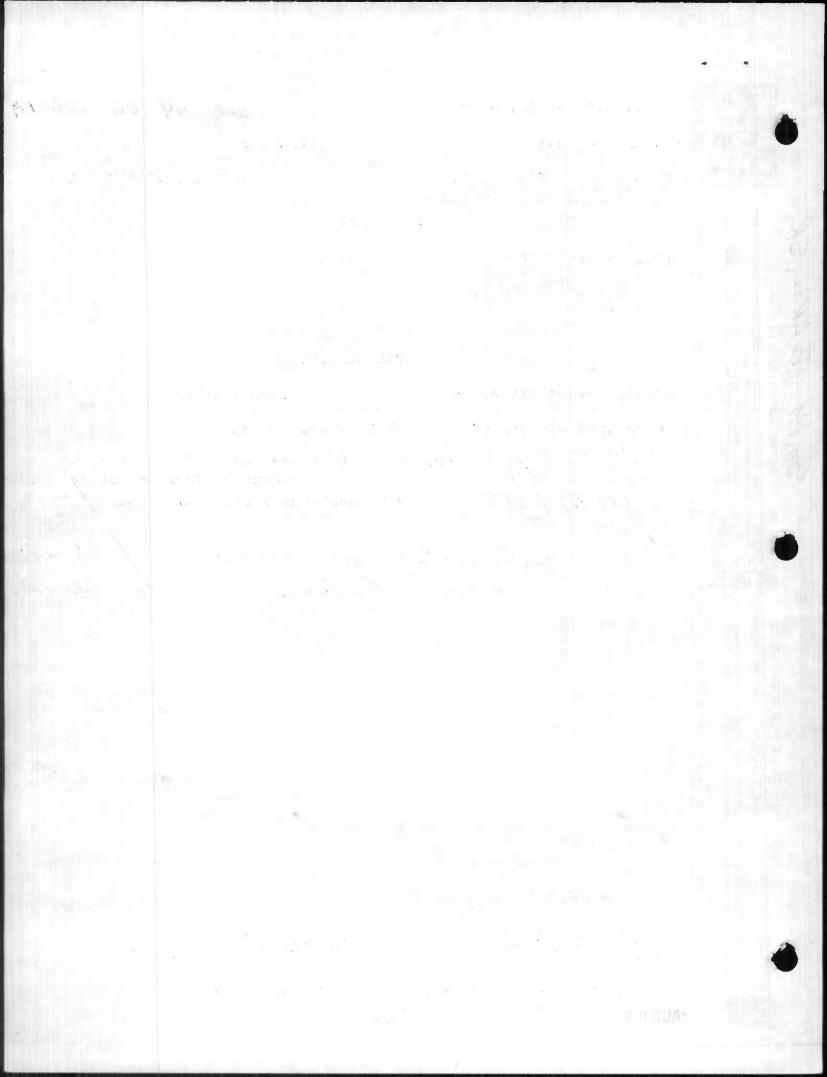
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Earl William Smith, 1250 PM /Medical 4b. City, Town, or Location of paeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Deaton Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1QM 2□ F Months Yrs. Director 218.42.6992 July 22, 1945 Maryland Usual Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Directo N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A.

14. Raca - American Indian,
Bleck, White, etc. 1132 Sargeant Street 21223 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Stetus 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: 1 □ Nevar Married 2 □ Married 1□ Yes 2□ No Specify: Specify: White 3 Widowed Wivorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bueiness/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Carpet Carpet Layer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) Be nd Mental marked o 2 Walter Edward Smith, Sr. Elsie Wheeler 19a. Informent's Nama/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 1132 Sargeant St. Baltimore, MD 21223 e of Disposition (Name of Dete 20c. Location - City or Town, State Rose Mariner/Girlfriend 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☐ Burial ②☐Cremation 3 ☐Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/7 Beltsville, MD 22. Name end Address of Facility Gary L. Kaufman Funeral Home noral Servica Licens 7250 Washington Blvd. Elkridge, elles MD 21075 er tha disease, or complications thet ceusad the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, aart failura. List only ona causa on aach lina. Approximata Intervel Betwaen Onset end Deeth **Physician** /Medical Immedieta Ceusa (Final diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examir Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) edical Dua to (or as a consequenca of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert 1. 23h. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Division of Vital Records, p 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of deeth? NA 1 Yes 2 No 200 No 25. Wes cese refarred to medical axaminer? 89 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Tima of 28a. Dete of Injury (Month, Dev Year) Certification: 5 Pending investigation 1 Naturel 1 Yes 2 Accident or Atten after dest Director: 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 24 hours 29a. Certifier Medical 🗷 Certifying Physician: To the best of my knowledge, daath occurred et tha tima, data end plece, end due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) end menner stated. To the To To the F 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nema and address of person who completed cause of death (Itam 23a) (Type, Print) 4231 Postal Court Pasadena, Md. 21122 C.J.Folkemer M.D.

32. Registrer's Signeture

Registrar

31. Date filed (Month, Dey, Year) AUG 0 8 2000



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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-	Examin	-	4a Facility Neme (If not institution, give stre	et end number)	•	4b. City Town, or	Location of Death	4c. County of	Death
4			BON Secour	e Hoss	lutil	PAI	177).	1	H
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	pt Dittilooy/	er 1 Yaar if Under 24 Hrs		9.	Birthplece (State or Foreign
	Director		212-44-6563 104	200F 56	Yrs. Months	Deys Hours Min	FOD CO	944	Country)
-			Usual Residence of Decedent				(20.0)	111	
	Maryland -f ahow		10a. State 10b. County	10c. City	Town or Location				10d. Inside City Limits
	the Maryle	to	MO NA		BAUL	MORE			1 Yes 2 No
	28a-f	Director	10e. Street and Number	. 1	10f. Z	ip Code	100	. Citizen of Wha	it Country?
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	deeth with the	era	XICO FOLLUNIU	Was Decedent Ever in U,S	13 Wes Dags	adent of Hispanic Origin? (Specify Vas or No-	14 Bace -	American Indian,
	items items	Funeral	V	Armed Forges,2	If Yes, sp	edant of Hispanic Origin? (secify Cuban, Mexican, Pue	to Rican, etc.)		White, etc.
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12	within ene.	m	Elementary/Secondery (0-12)	College (1 stor 5+)	life. DO NOT	28/01		٨	14
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in o	be filed with that Hygiene d other the event, the	Be	17. Father's Neme (First, Middla, Last)	1.		18. Mothers Ne	me (First, Middle, Ma	iden Sumeme)	
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Maryland	N 0 0 2		19a Informant's Name/Reletionship (Type,	Print) (1 OT)	19b. Meiling Addres	ss (Street end Number or A	urel Route Number (ity or Town, Ste	ete, Zip Code)
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Baltimore,	of Heel		20a. Method of Disposition	100	ace of Disposition (Na malery, crematory or	ame of other place)	Date 20	c. Location - Cit	y or Town, Stete
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=	Depertment mportant any injury		21. Signature of Funeral Service/Licenses	0.1	22. Name	and Address of Fecility	Children of the	M	and the right of
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-			23e. Per 1. Enter the disease, or complicate shock, or heart failure. List only or heart failure.	ausa on aach line.	. Do not enter the mo	ode of dying, such as cardie	c or respiratory arres	Į,	Interval Between Onset and Death
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Calde	ac	accept			
		_	resoning in death)	Due to (or	es a consequence of	in lands	3		
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	be executed lcian and bunal-transit	Examiner	Sequentially list conditions,	Due to (or	as a consequence of):			
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9	death certificate e attending phys od for use es the	Me		The loom	BOCH	topen	ua		
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		SCI	Pert II. Other significant conditions contrib	uting to death but not resul	Iting in the underlying	cause given in Part I.	23b. Did tob	acco use contri	bute to the cause of death?
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	within 2. To the F complet	Med	one)	and manner stated.					
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	(30. Name and addrass of person who comp	leted cause of death (Item	23a) (Type, Print)	ANURADH	A REA	124	
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Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day + IRENE STEINBERG August 2000 0725 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Hospital Dina: If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Months Days 10 M 20 F Yrs. 1915 85 218-03-3238 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 4000 FORDS LANE #1D 21215 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify SpecifWHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) BOOKKEEPER PRODUCE 18. Mother's Nama (First, Middle, Maiden Surneme) 17. Fathar's Nama (First, Middle, Last) SAMUEL STEINBERG LENA BORDANSKY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) DR. LEON STEINBERG/BROTHER 2703 GLEN AVE. BALTIMORE, MD. 21215 20b. Place of Disposition (Neme of cemetary, cramatory or other place) (ANSHE EMUNAH)—AITZ 20c. Location - City or Town, State 20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ Removal from State CHAIM CONGREGATION 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensae Tole 8900 REISTERSTOWN RD. PIKESVILLE, MD21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immediate Cause (Final disease or condition rasulting in death) Pulmonary Edema Due to (or as a consequence of): Heart Failure ongestive Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Hypertension Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Insulin Dependent Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? COPD 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

The lew requires that the deeth certificate be execu

Box 68760.

P.O. I

Division of Vital Records.

permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygien. Important: if item 27 ie merked other that any injury or other traumetic event, the page.

Physician

/Medical

MD.

Director

Funeral

by

Completed

Examiner

Funeral

Director

than "natural", or items 23s or 28s-f show

Maryland 21215-0020

Baltimore,

traumatic event, the Medical Examiner must be notified at

Examine Physician/Medicai þ Completed Be

Physician: After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical

State

Registrar

attending physician for use as the bune signed by t certificate Certification: To

29b. Signatura and title of certified

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

29a Cartifier

april 30. Name and addre

5 Pending investigation

6 Could not be determined

of person who completed cause of death (Item 23a) (Type, Print)

28a. Data of Injury (Month, Dey Year)

29c. License number

28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dev. Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d Describe how injury occurred

August 4,2000 W. Belvedere Ave Baltimore, MD

Patrick 31. Date filed (Month, Dey, Year) AUG 0 8 ZUUU

M. Ginley 2401 32. Registrar Signatura

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

W. B. Warren and Balancey M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) -2. Date of Deeth Month **Physician** Mane 2000 mas /Medical 4b. City, Town, or Location of Path 4a Facility Name (# pd institution, give street end number) 4c. County of Death Examiner Baltimore och Race 2 Idecorce zenesis If Under 24 Hrs. 8 Date of Birth Hours Min (Month, Day Year) If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 10 M 2 F Months Days Yrs. 226 - 25 - 1458 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Baltimae Directo Maryland "natural", or items 23s or 28s-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Aubruz Belvedere S. A 17pt.D 21239 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11 Maritel Status filed within 72 hours after 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: þ hite 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown MYNOW Homemaher permit. Pages 1 and 2 should be life. Department of Health and Mental Hy important: if them 27 is mercer any Injury or 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) E. Hurst flou don 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Burel Route Number, City or Town, State, Zip Code) 17327 Emma 20a. Method of Disposition Cusich-Stop Davihter RR3 Glen Roch Baitimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 8/1/00 Hill Memorial Hark 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Chapel Road 21093 teson 2325 Yah Timonium that caused the deeth. Do not enter the mode of dying, such as cardiac or Enter the disease, or heart failure. L. Approximate Interval Between **Physician** /Medical Immediate Cause (Final nermoni disease or condition resulting In death) Examiner Physician/Medical Examiner heimer's diseas To the Hospital or Attending Physician: The law requires that the death certificate be assected within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, it any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 2 2 No 1 Yes 2000 1 Yes 25. Was cese referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a Certifier

Registrar

31. Date filed (Month, Day, Year)

5601

30. Name and address of person who

Loch

29b. Signature and title of certifier

AUG 0 8 2000

32. Registrar's Signature

Bu completed cause of death (Item 23a) (Type, Print)

Boulevard

29c. License number

Bultimore, MD

D00525+3

21239

29d. Date signed (Month, Day, Year)

31

2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 34 **Physician** ITTEMAC (AMES August 7 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) **Examiner** NONTHWEST HESPITAL CENTEN PANBALISTONN BALTIMONE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 4-30-14 6. Sex 1 M 2 ☐ F 9. Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Yrs. 246-16-7748 26 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director BALTIMORG mo 10e. Street and Number 101. Zip Code 10g. Citizen of Whet Country? 1910 W. FAYEHE 54 21223 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Domino SUGAL Elementary/Secondary (0-12) College (1-4or 5+) FIREMAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) LAURA ADAMS 2 UNKNOWN 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hildred Coleman Doughter 1910 W. FAYEHE ST BALOS NA 212 23 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from Stete KINC HEMORIAL DK. 8/12/00 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MONTON-50 HS 21. Signature of Funeral Service Licental BAL10. MD. 21217 1701 LAUNGUS ST Mon 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Savent Immediata Cause (Final disaese or condition resulting in death) /Medical OBSTRUCTIVE PULLOVERY DISTASE Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degith? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy Be Completed Sock SINNS Syndnome Anos TATIO 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DiNatural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

Attending Physicien: The lew requires that the deeth certificate be executed Box 68760 P.0. Records, Division of Vital To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al

28a-f ehow

tem 27 ie marked other than "natural", or frama 23a or 28a-f eho other traumatic event, tve Medical Examiner must be notified

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked oths any Injury or other traumatic event

21215-0020

Maryland

Baltimore,

State Registrar

completely

Medical

31. Date filed (Month, Dey, Year) AUG 0 8 2000

ORIANDA

29a. Certifier

(Check only one)

29b. Signeture and title of certif

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) CONTALIN 32. Pegistrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner steted.

29c. License number

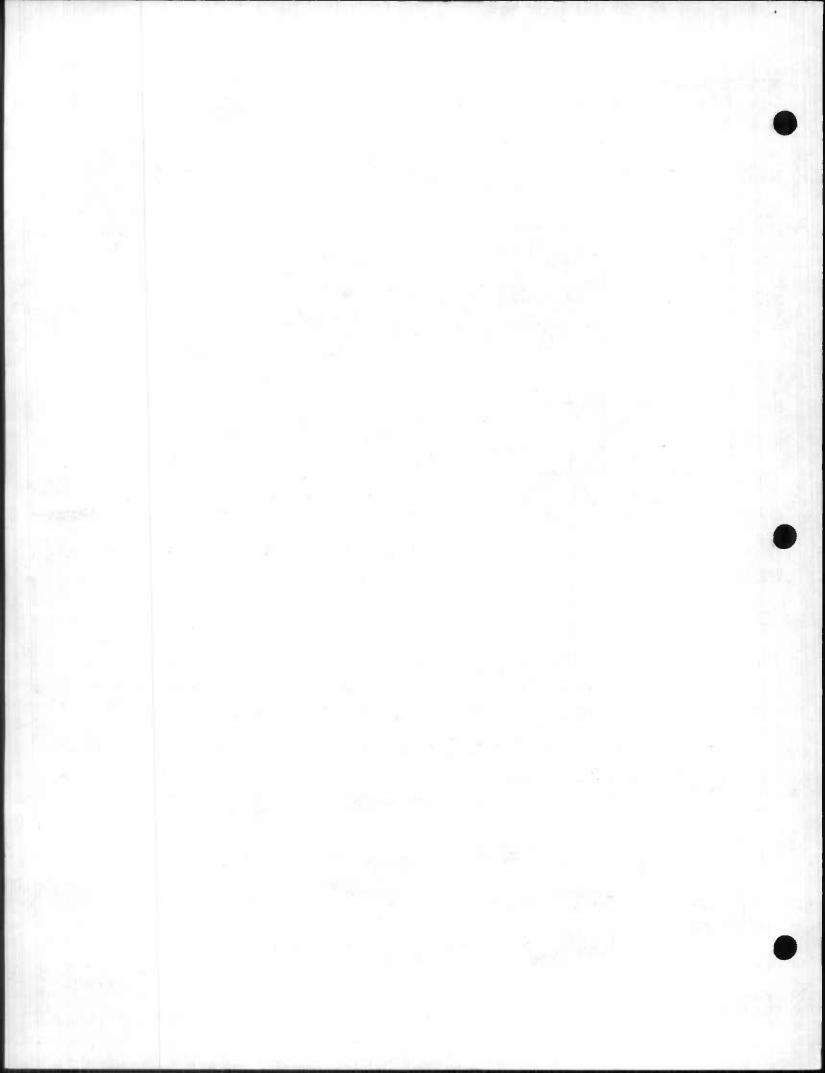
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State of Maryland / Department of Health and Mental Hygiene

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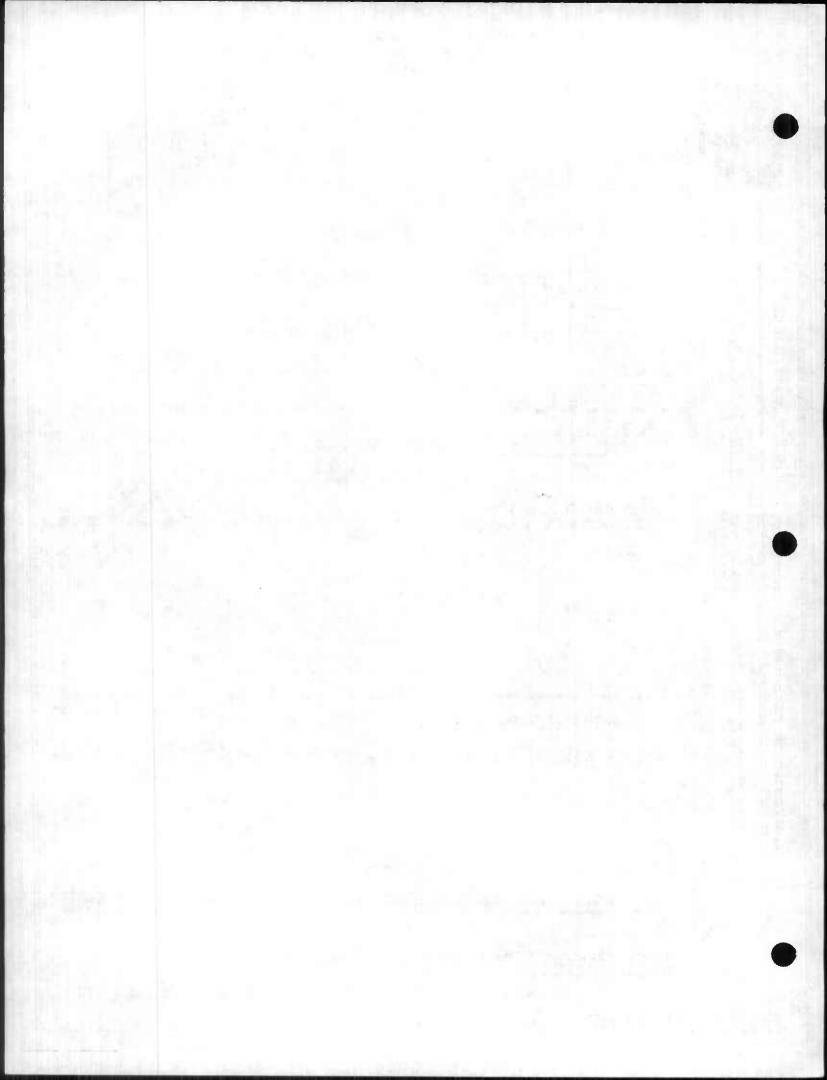
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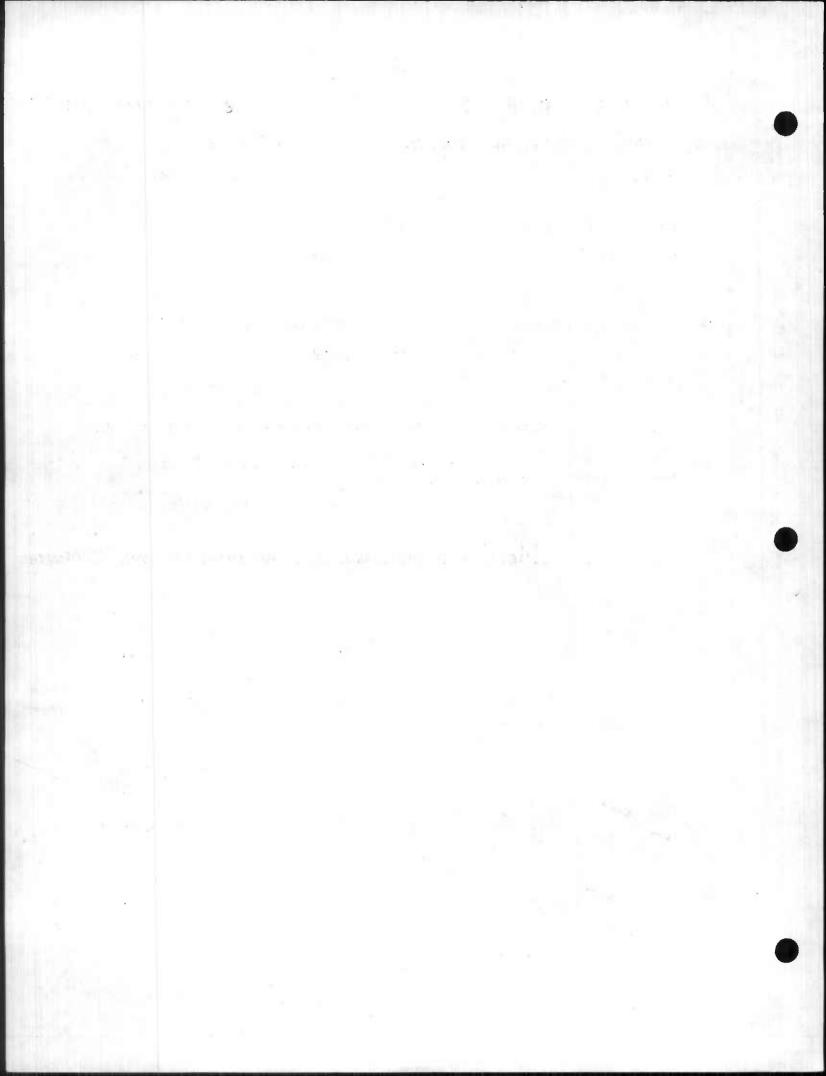
State of Maryland / Department of Health and Mental Hygiene 24928 Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) August 2 **Physician** 7:20 PM 2000 Richard Clayton Tyree /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner GLEN BURNIE ANNE ARUNDEL NORTH ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Dafe of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F Days Yrs Director 219-26-7004 62 Feb. 9,1938 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 € No Directo 288-4 Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code b 238 172 Oak Drive 21122 USA Funeral 14. Reca - Amarican Indian. 12. Was Decedenf Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Dates: 1 Never Merried 2K Married natural, or 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Senior Tech. Writer Westinghouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middla, Last) Harold Holt Tyree Olivia Easter 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) epartment of Health ar reportant: If Item 27 is Aleta Tyree/Wife 172 Oak Drive, Pasadena, Maryland 21122
pe of Disposition (Name of Date 20c. Location - City o 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition 1 ☐ Buriel 2 M Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Cr. 8/7/00 Laurel, Maryland 22. Nama and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee m00741 1630 Edmondson Avenue, Catonsville, MD 21228 Handa semmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) 3 weeks /Medical SEVSIS Examiner Due to (or as a consequence of) Examine DIABETES INSULIN DEPENDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last and Dua to (or as a consequenca of): physician Box 68760 Physician/Medicai Due to (or as a consequence of) P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE, PERIPHERAL signed by Division of Vital Records, p VASCULAR DISEASE, DISSEMINATED INTRAVASCULAR performed? 24b. Were autopsy findings evailable prior to Completed completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Tyes 2 No COAGULATION 25. Was case rafarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred or Attending Patter death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Deta signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier EUffer wown up who completed cause of death (Item 23a) (Type, Print) 30. Nama and addrass of person 1600 CRAIN HWY, GLEN BURNIE, MD. GEOFFREY SAUNDERS M.D. 31. Data filed (Month, Day, Year) 32. Registrer's Signature State AUG 0 8 2000 Registrar sour.



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						iai y iai		Certifica		Death		Reg. No.		
	Bl		1. Decedent's Name (First, Mic	ddle, Lasi	")						2. Date of De		Year	3. Time of Death
	Physicia /Medic	al	ROBERT	TI	RICE.	SR		300			08		2000	17:55
	Examin	_	4a Facility Nama (If not institu	lion, giva	street and riomber)				4b. City, Town, or L	ocation of Deat	4c. Count	y of Death	
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	Funeral		5. Social Security Number	6. Se	X 7. A	ge (In yrs.		rs. Months	or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Data of Bir (Month, Da		Coun	
	Director	-	212-20-5898 Usual Residence of Decedent				3				June 2	, 1927	Ma	ryland
	rand M		10a. State 10b. Cour	nty		10c. Ci	ty, Town	or Location					1	Od. Inside City Limits
	Man Man	tor	Md. N/A			F	alt.	imore						1 Yes 2 □ No
	A ZB	Director	10e. Street and Number				7410		ip Code			10g. Citizen of	What Cour	ntry?
			2813 Ganley D	rive				- 4	21	230		U.S	.A.	
	0 and	Funeral	11. Marital Status		12. Was Deceden Armed Forces	t Evar in U	,S.	13. Was Dec	edent of h	fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Ra	ce - Americ	
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Maryland 21215-0020	n 72 net	leted	15. Deced (Specify only high	ent's Edu ha <i>st grad</i>	le completed)		16a.	Decedent's Us (Give kind of w	ual Occup ork done	pation during most of work d)	ing	16b. Kind of E	Jusiness/Inc	dustry
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P			17. Father's Nama (First, Midd	la, Last)	0		1	opi ay i	u i i i c	18. Mother's Nam	e (First, Middle			110.
lan		To Be	Willis Albert	Tri	ce					Annie	Helen	Kellv		
any	ahou and N		19e. Informant's Name/Relation	nship (T)	rpe, Print)		19b.	Meiling Addres	ss (Street	and Number or Rur			n, Stete, Zip	Code)
	and 2 27 in		Gertrude Tric	e 1	Wife)		28	313 Gan	lev	Drive Bal	timore.	Maryla	nd 21	230
Baltimore	of the		20a. Method of Disposition	,			Place of	Disposition (Na., crematory or	ame of		Date	20c. Location	- City or To	own, State
Ĕ	Pag nent: It		1 ☑ABurial 2 ☐ Cramatio 4 ☐ Donation 5 ☐ Other				vla	nd Vete	rans	Cem. 8	/7/00	Crownsy	ille.	Maryland
alt	Ponta Ponta y ind		21. Signature of Edneral Servi	ce Licens	∞Kevin E			22. Name a	nd Addre	ss of Facility				
B	88188		4/1					237 F	Ty-Pi	olyniak F	uneral	Home, P	.A.	land 21225
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	Physician			, .										Onset and Death
	/Medical Examiner		Immediata Cause (Final disease or condition		METAS	TATI	CK	ION-SMI	IL C	ELL CAR	CINDMA	OF LU	VVG	10 MONTHS
ı			resulting in death)					onsequence of						
	Do tis	Examiner			b								-	
	ifficate be executed g physicien end es the burial-trensit	xar	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying			Due to (d	or as a c	onsequence of):					
68760,	Sicient Durit		cause. Enter Underlying Cause (Disease or injury that Initiated avants	4	c									
687	ficate phy s the	edical	resulting In death) Last			Dua to (d	or as a co	onsequence of	:					
Вох	nding	3			d									
	death cer e attendir ed for use	2	Part II. Other significant cond	Hone on	otributing to death	but not rec	ulting in	the underlying	cause ai	yen in Part I	23h Did	tobacco use co	ontribute t	o the cause of death?
P.0.	e law requires thet the death cert has been signed by the attendin ge 2 should be detached for use	by Physician/M	raith. Other aigninicant cond	itions coi	inibuting to death	out not 10s	outeig ei	the underlying	cause gir	von stratti.	1/9	Yes 2 No		bebly 4 Unknown
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ğ	law requires that the as been signed by the 2 should be detache	8									24a. Wes	an autopsy	24b. W	ere autopsy findings allable prior to
900	s bed 2 sho	plet					-				pon	Jilliou :	CO	mpletion of cause death?
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ta	delan: The		25. Was case referred to medi	cel						26. Place of Deal	h (Check only	one)		
>	nysici iis ce direc	0	axaminer? 1 ☐ Yes 2 ☐ No	ŀ	lospital:	ient 2	ER/Out	patient 3 C	Ott	ner: 4 Nursing Ho	ome 5 Res	dence 6 🗆 Ot	ther (Specia	(y)
Division of Vital Records,	ng Pt her th	Ë	27. Manner of Death 1 Matural 5 ☐ Pen-	dina	28a. Dete of Inj (Month, D	ury ey Year)	28b. Ti	ime of jury	28c. Inju	ry at	28d. Describe	how injury occu	irred	
Sio	endir or: A	Sati	2 Accident inva	stigation				М	10	Yes 2□No				
Ž	frech frech in by	Certification:	3 Suicide 6 Cou 4 Homicide dete	rmined	28e. Place of In building, e	njury - At h etc. (Specil	ome, far	m, street, facto	ry, office		281. Location (City or To	Street and Num wn, Stele)	ber or Run	al Route Number,
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	0.0		30. Name and address of person	1		death (Iter	n 23a) (1	ype, Print)	1 61.		at R	11/1	M	lod 21230
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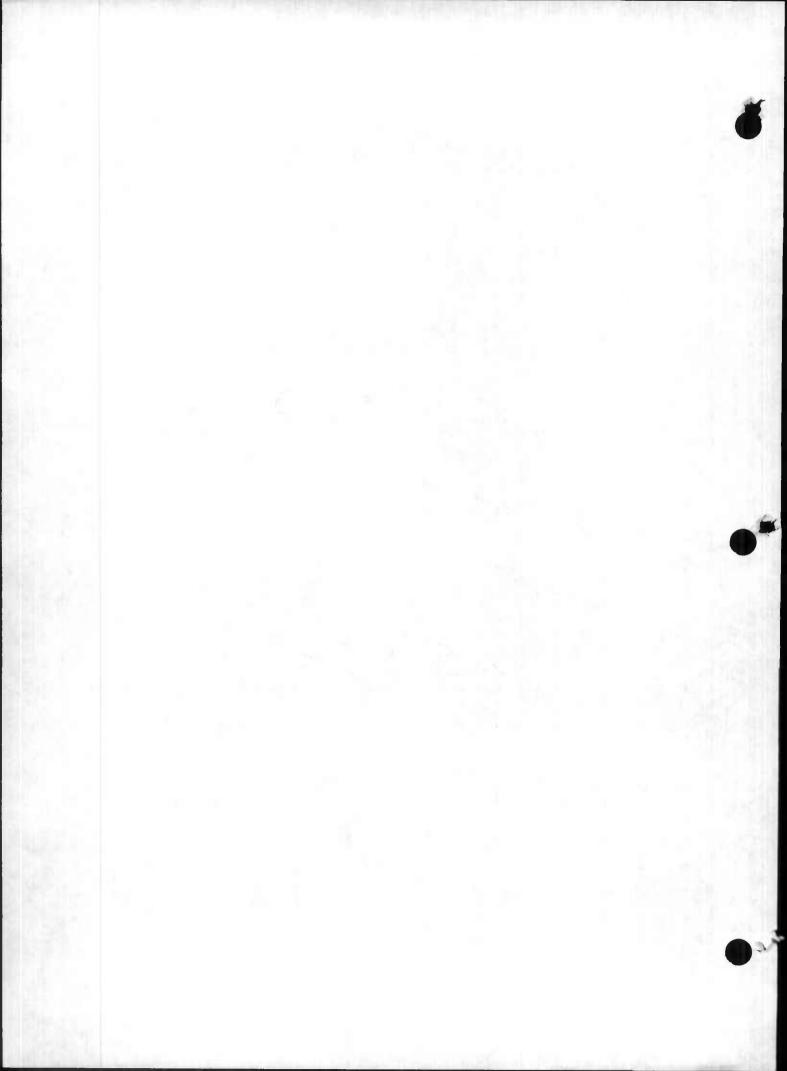
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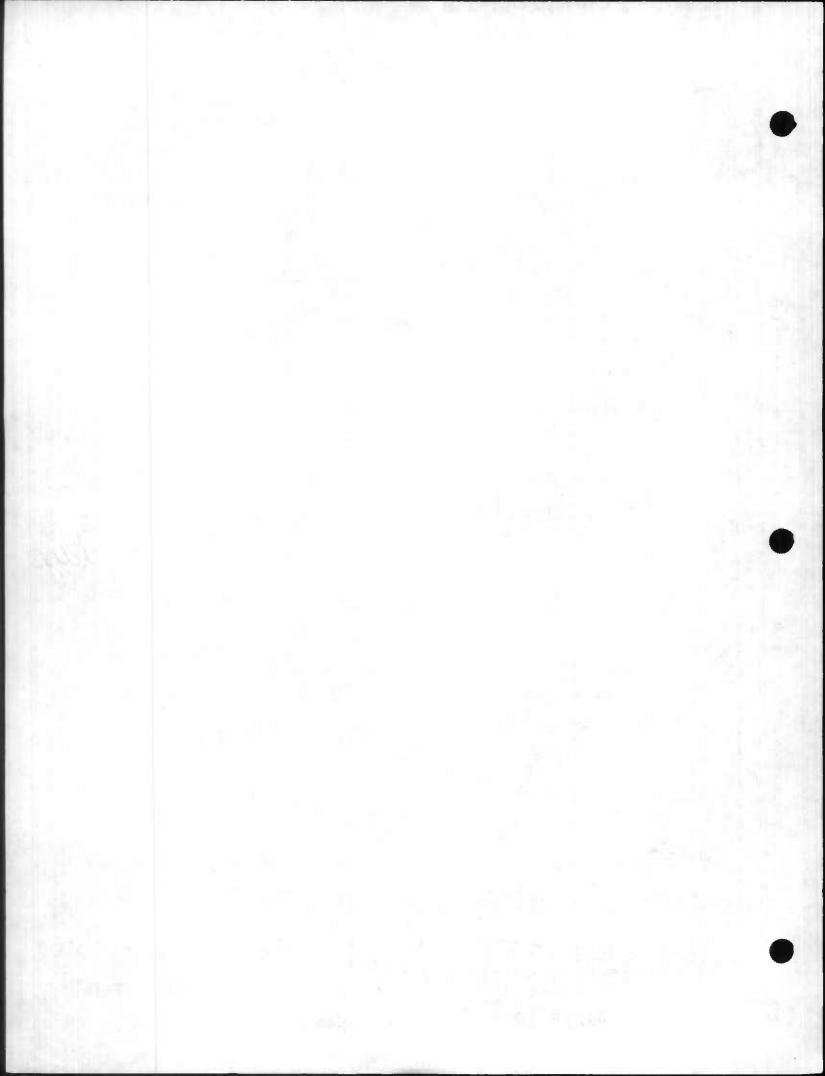


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State of Maryland / Department of Health and Mental Hygiene

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Physici /Medic		1. Decedent's Name (First, Middle Mary Josep		homas						2. Data of Dea Auguits t		O O Com	3. Time of Death 2:00 Pivi
Examin		4a Facility Name (If not institution 508 Sylview		umber)					ader		Anne	y of Death Arun	
Funeral Director		5. Social Security Number 401-28-0423	6. Sax 1 □ M 2 ☑ F	7. Aga (In yrs	last birthday) 77 Yrs.	If Under 1	Yaar Days	If Undar	24 Hrs. Min.	8. Data of Birth Month, Day Sept. U	5 ⁷ 1922	9. Birth	place (Stata or Foreig CUCKY
Maryland H ahow	tor	Usual Residence of Decedent 10a. Stata 10b. County Maryland Anne	Arundel	10c. C	ity, Town or Lo						-9.7		10d. Inside City Limits 1 ☐ Yes 2 X No
h with the	al Director	10e. Street and Number 508 Sylview	Drive			10f. Zip C		21122			10g. Citizen of	What Cou USA	intry?
filed within 72 hours after deeth with the Maryland Hygiene. Iffer than "natural", or items 23s or 28s-f show int, the Medical Exeminar mant to notified a	by Funeral	11. Maritai Status 1 Nevar Married 2 Marr 3 Widowed 4 Divorced	Armed F	2 💢 No Sive	- 11	Vas Deceder f Yas, specify l □ Yes 25	Cuba	ispanic Ori an, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No- Rican, atc.)		ack, White,	
within 72 hours ene. then "netural", for Medical Exp	Completed	(Specify only higher Elementery/Secondary (0-12)	1	(1-4or 5+)	(Give	lent's Usual (kind of work OO NOT use	done i retired	ation duning most	t of work	ing	16b. Kind of E		
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2552		19a. Informant's Name/Relations Lewis M. Thomas)						al Route Numbe asadena			ip Code)
Pege Int: If I		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other (S	pecity)	n State	Place of Disponentery, cremetery, cremetery	ematory or other	y,	Inc.		ug. 07 2000	20c. Location Balti		own, State , Maryland
Departra Importa eny inju		21. Signatura of Fuperal Sanica	bioerhoe /		22	3111 M	Addre 10UI	ss of Facilit ntain	N St Roa	allings d, Pasad	Funera dena, M	lary la	ned 21122
Physician /Medical Examiner	liner	23a. Part : Enter the Greeke, or shock, or heart favore. List Immediate Cause (Final disease or condition resulting in death)		erek		usq				Acci	,	+	Approximate Interval Between Onset and Death
eath centricete be executed ettending physician and for use es the buriel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last	c		or as a conseq								
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iclen: The law certificate has b rector, page 2 s	se Completed	25. Wes case referred/to medica				Ay?	1	26. Place	of Deat	1 □ Y			☐ Yes 2☐ No
r this	ion: To B	axaminer? 1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pendin	28a. Dat (Mo	Inpatient 2 De of Injury onth, Day Year)	28b. Time of Injury	280	Wor	y at k?	ursing Ho	ome 5 Resid		ther (Spec	ify)
free deat	Certification:	2 Accident investi 3 Suicida 6 Could 4 Homicide	not be 28e. Plac	ca of Injury - At I	nome, farm, str ify)	eet, factory, o		Yes 2	No	28f. Location (S City or Tow		nber or Rui	ral Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled		29e. Certifier (Check only one) 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, and manner stated.									cause(s) and n dete end plece	nanner es e, end due	stated. to the cause(s)
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(V) Sta	te	30 Name and address of person Jenni Terki 31. Date filed (Month, Day, Year)	edinge	Registrar's Sign	79-1	Print)	15	Hol	2 F	ed Se	verna	Par	1, 2000 LK MD.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 24932 Certificate of Death 3. Tima of Death Date of Death 9:45 P.m Month Thans 2,000 4b. City, Town, or Location of Douth 4c. County of Death Anne A Rundel

Funeral

Physician

/Medical

Examiner

Director 28a-f show Director ò fterns 23a Funeral Completed

py

Be

2

other traumetic event, the Medical Examiner must be notified at permit. Peges 1 and 2 should be filed within 72 hours aft Depertment of Health and Mental Hygiene. Intropramt: If Nem 27 is marked other than "natural", or is any Injury or other traumatic event, the Marked other than a

Baltimore, Maryland 21215-002

2nder]

Physician /Medical Examiner

the burial-transit the death certificate be executed and attending physician 88 9SU the signed by ti page 2 has certificate After this funeral the

Box 68760

P.O.

Division of Vital Records,

Examiner Physician/Medicai by Completed Be 2 Certification: To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After illed in by edical

1. Decedent's Name (First, Middle, Last) ROBERT JOSEPH VACEK 4a Facility Name (If not institution, give street and number) Glen Burnie

ar If Under 24 Hrs. 8. Date of Birth
Min. (Month, De)

122 / 19 North Arundal Hospita 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Months Days 1**X** M 2□ F 7/22/1938 212-36-5982 62 Yrs Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 ☐ Yes XX No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 155 Arundel Rd. 21122 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 D No
If Yes, Give
Yaar or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black Whita, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Greenway Bowl 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) James Vacek Dolores Leudke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Vacek - wife 155 Arundel Rd., Pasadena, MD 21122 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State **Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. PK 8/4/00 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FINK FUNERAL HOME, PA Lucgon 426 Crain Hwy., SW, Glen Burnie, MD 21061 Relly Gregory Fink 23a. Part Lenter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Les only one cause on each line. Approximete Interval Between Onset and Death Immediata Causa (Final diseese or condition resulting in death) JETS13 Due to (or as a consequence of) PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24a. Was an autopsy performed?

23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown

24b. Wera autopsy findings available prior to completion of cause of death?

22 No

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 Yes 2√ No 27. Manner of Death Natural

Inpatient 28a. Date of injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

Hospital:

28b. Time of

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury et Work? 1 Yes 2 No

28d. Dascribe how injury occurred

26. Place of Deeth (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dey, Year) 29c. Licansa number

29b. Signature and title of certifier

2000

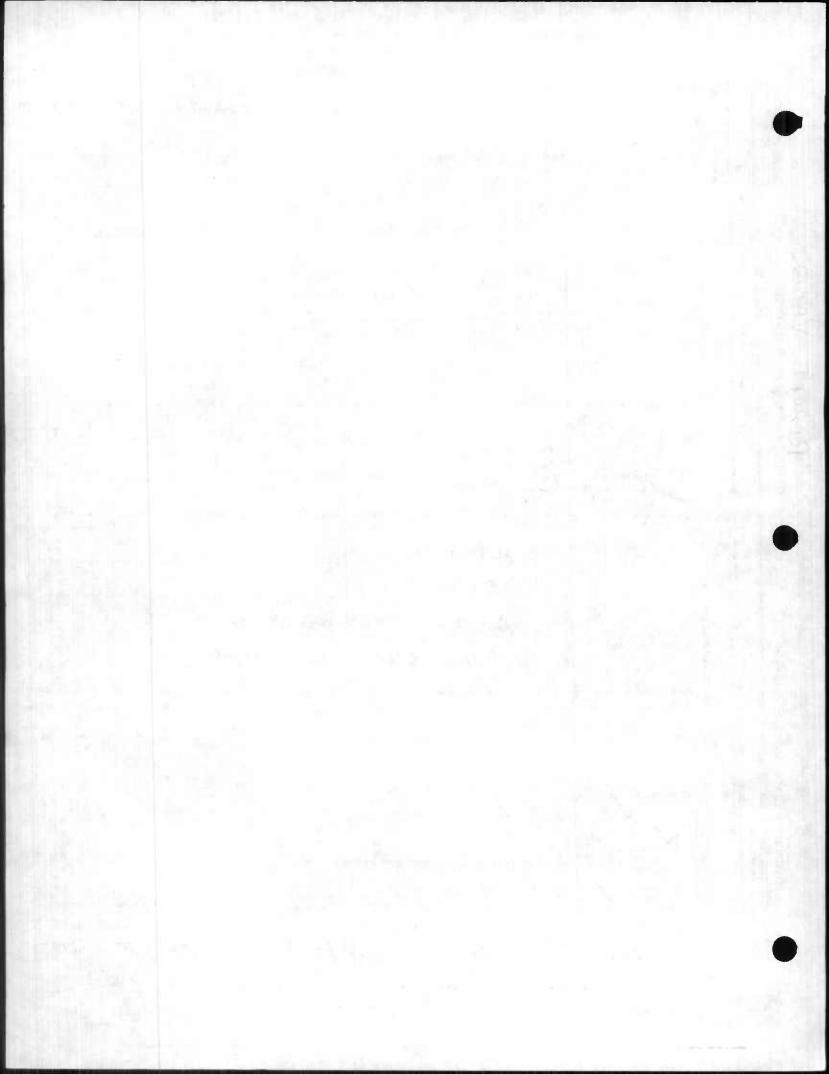
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nn

301 Merun 8 2000

Gley Bulne un

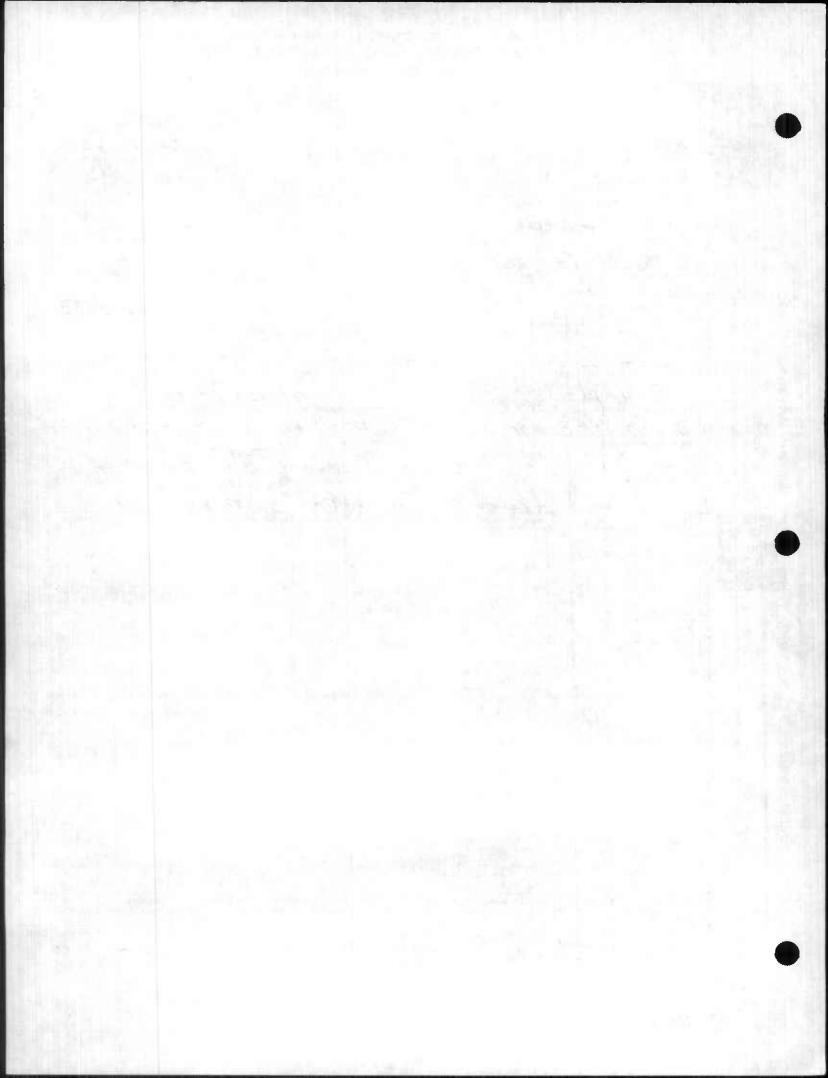
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death		Reg. No.	0 24933.
		H	Decedent's Nama (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	Physici /Medic		STANLEY	A. in	رامر	rcik	20	7		000 11:20 H.
	Examir		4a Facility Name (If not institution, give street	t and number)		4	b. City, Town, or Lo	cation of Death	4c. County of	Death
			MARINER HEALTH	CARE OF	FLA	TONSVILLE	CATONSY	THE	BAUTI	MORE CO.
	Funeral		5. Social Security Number 6. Sex	2 F 7. Age (In yr.	-	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dala of Birth (Month, Da)	, rear	Birthplaca (State or Foreign Country)
	Director		Usual Residence of Decedent	6	7			NOV.	1930	MD.
	Mand Mand		10a. State 10b. County	10c. (City, Town	or Location				10d. Inside City Limits
	Mar	io	MD. BALTIMO	RE (CAT.	ONSVILLE				1 Yas 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Whe	al Country?
	23a		98 SMITHU	100D		212	28		0.5	· A .
	terms	Funeral		Vas Decedent Evar in Armed Forces?	U,S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, atc.)		Amarican Indian, White, etc.
20	hours after death with the Manyand tural', or items 23a or 28s-f show it Everninet must be notified at	by F		Yas 2 No 1 Yes, Give Yaar or Datas:		1□ Yes 2NNo	Specify:		Specify:	11916:55
21215-0020	natural',		15. Decedent's Education		16a.	Decedeni's Usual Occup	ation		16b. Kind of Busin	ness/Industry
212		Completed	(Specify only highest grade cor	npleted) College (1-4or 5+)	_	(Give kind of work done of life. DO NOT use retired	duning most of working	ng		
21	d within giena. or than	E O	Elementary/Securidary (0-12)	Johaya (1-401 54)		SEAMAN)		SHIPS	5
pu	be filed trail Hygi d other event, n	Be	17. Father's Name (First, Middla, Last)	0	,		18. Mother's Name	(First, Middle,	Maiden Surhame)	
yla	Mer Mer artic	2	JOHN M. U	OJCIK			AGN	ES 1-1	LASIK	
Maryland	U a a a		19a. Informani's Name/Relationship (Type, i	Print)	19b.	Mailing Address (Street	and Number or Rura			
	Health tem 27 other to		20a. Method of Disposition	SK1	Place of	Disposition (Name of	PRD.	DA-UII	YORE, MY 20c. Location - Ci	
Baltimore	0 ± 5		1 ☐ Burial 2 Cremation 3 ☐ Remo		cemeter	y, crematory or other place	'	ULYZY		
Ē	E # 2		4 Donation 5 Other (Specify) 21. Signature of Feyneral Service Licensee		AYV	22. Name and Address	11 /	2000		MORE, MD.
Ba	Depenting Dependent Importar any Injure once.			1 00		Clara A E	-11 282	9 HUD	JON ST	
H			23a Part 1 Enter the disease of complication	ons that caused the de	eth Don	of enter the mode of dvin	n such as cardiac o	CTO. M	1D 2/22	Approximate
	Physician		23a. Part1. Entar tha disease of complication shock, or haart failure. List only one ca	use on each line.						Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition		CA	7)				1/21
п	Examiner		resulting in death)	Due to	(or as a c	consequence of):				10.
	D #	Examiner								
	ne death certificate be axecuted the attending physician and shed for use as the burial-transit	ж	Sequentially list conditions,	Due to	(or as a c	onsequence of):				
,60	ificate be axecut g physician and as the bunal-trar	BE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	55.0						
68760	ficate phys	edical	resulting in death) Last	Due to	(or as a c	onsequence of):				
Вох	nding use a	3	d						- 27	
m.	v requires that the death cer been signed by the attendin should be deteched for use	Physician/N	Part II. Other significant conditions contribu	ting to death but not r	esulting in	tha underlying causa giv	an in Part I	23b. Did t	obacco use contr	ibute to the cause of death?
P.0.	by the	hys								Probably 4 Junknown
	gned b	by	117		4	T.1				
Division of Vital Records,	requires ween sign hould be	Completed by	Parex	s p m.	7).	56			an autopsy med?	24b. Ware autopsy findings available prior to
ec	S S S	ple	4.11.	g man	lon	illy lung	Cance	/		of death?
=	The pege	Con	112 000	<i>t</i>	-//			101	as 2000	1 ☐ Yas 2 ☐ No
Vita	Physician: The law this certificate has ral director, page 2.	Be	25. Was casa referred to medical examiner?	ital:		Oth	26. Place of Death	(Check only o	ne)	
of	Physician: this certific	7.	1 195 20140	1 ☐ Inpatient 2	ER/Out	patient 3LI DOA	4 Nursing Hor		ience 6 Other	
On	al or Attending P s after death. f Director: After to d in by the funera	tion	Natural 5 Pending 2 Accident investigation	(Month, Day Year)		njury Wor	k? Yes 2□No	.bd. Describe i	iow injury occurred	
/ISI	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be	Be. Place of Injury - At	home, fai	rm, street, factory, office		28f. Location (S	Street and Number	or Rural Route Number,
ā	s afte	Certification:	4 Homicide	building, etc. (Spec	city)			City or Tou	vn, State)	
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only 2 Medical Examiner:			death occurred at the tin				
	the H	Medi	one)	and manner stated.	- I	7				
	To To	Σ	29b. Signature and title of certifier	the		29c. Licens		1	290. Date signed (Month, Day, Year)
J	3		16	-0.	1	-	36942		7-7	21,2000
	w.	1	30. Name and address of person who comple	ited cause of death (It	em 23a) (Type, Print)	009 F	CEN	ENNI	r Rd.
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Sig	natura	177	0071	/C'- 0	2,0,0	C V 1 - C
	اد Registr	_	AUG 0 8 2000 Sen	evas 19	1	ooks				



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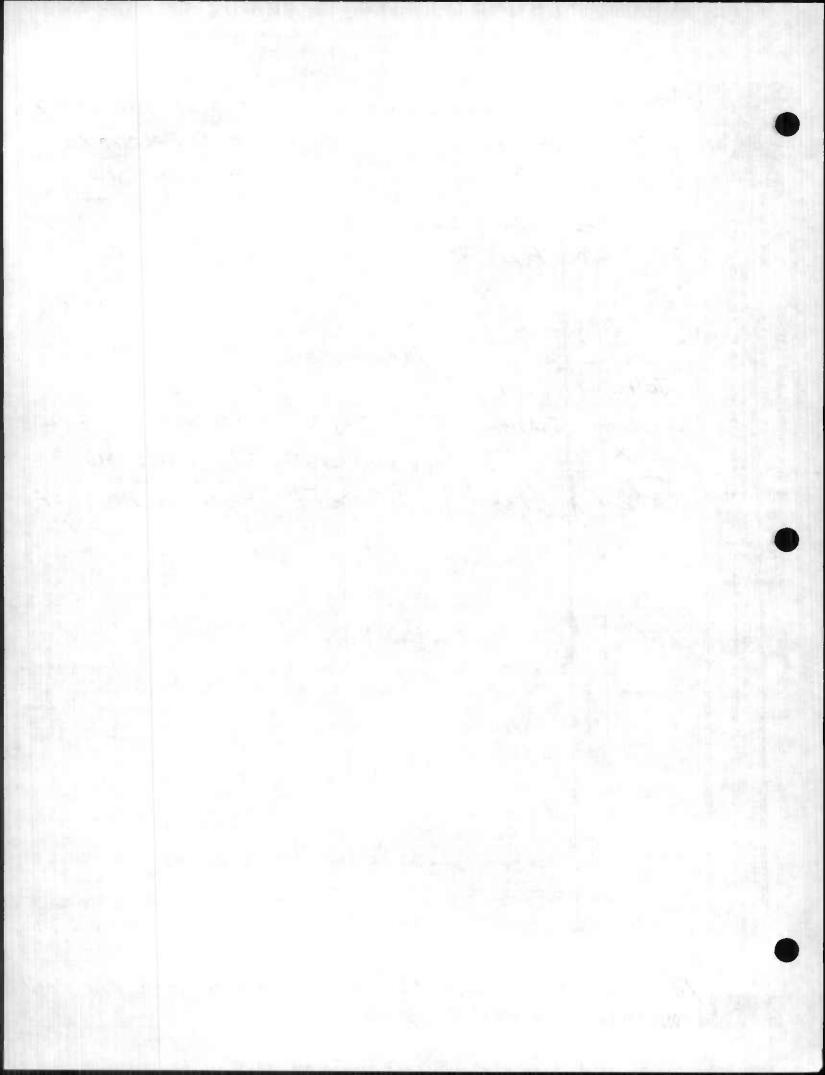
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

24,934

					001	unicate or	Death	Re	g. No.	
· 1	Physicia /Medic		1. Decedent's Nema (First, Middle, Last BERTHA V	, WASI	ELEU	usKi		2. Dete of Deeth Month	Day 2	Year // 55 M
	Examin	er	4a Facility Neme (If not institution, give	street end number)	27		lb. City, Town, or I		4c. County	
10.00	,		5. Social Security Number 6. Sa	E PTTPM F	a. last birthday)	If Under 1 Year	EDGEMA If Undar 24 Hrs.	6 Date of Righ		TIMORE OF STATE OF FORMICE
	Funeral Director			M 2XF 78	Yrs.	Months Deys	Hours Min.	Month, Day,	922	Birthplace (State or Foreign Country) Country
	land		10a. Stele 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Many Hash	to	MD BAITI	MORE E	EDGEN	1ERE				1 No 2 No
	r 28	Director	10e. Street and Number	/		10f. Zip Code		10	g. Citizen of W	
	23a	alc	2825 LODGE	FARM RI).	2/2	.19		0-3	5.A.
- (ed a se	Funeral	11. Marital Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13.	Wes Decedent of H f Yes, specify Cube	lispanic Origin? (S en, Maxican, Puart	pecify Yes or No- o Rican, etc.)		- Amaricen Indian, k, White, etc.
3-0020	within 72 hours effer deeth with the Maryland ene. - Anna "estural", or terms 23a or 28a-f show - Medical Examinar must be notified a	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yaer or Dates:		1□ Yas 2 No	Specify:		Specify:	WHILE
ח	nath	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usuel Occup kind of work done DO NOT use retired	etion during most of wor	king	6b. Kind of Bu	siness/Industry
1717	filed withir Hyglene. Ither than	Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	Ho	MEMAI	KER			HOME
	S d a S	To Be	17. Father's Name (First, Middla, Last) Jo/fw//	SOHN			BirLin	ne (First, Middle, Ma EN ST	iden Sumem	DELL
	d 2 should h and Mer 7 is marke traumatic		19a. fnformant's Name/Reletionship (T)	pe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	irel Route Number,	City or Town,	Stete, Zip Code)
2,	r Heelth tem 27 other tr		WILLIAM J	OADAN	380	O BAY	DR. K		ORE	MD. 2/220
More	00-		20a. Mathod of Disposition 1 ☐ Buriel 2 ★ Cremetion 3 ☐ F		Plece of Dispo	sition (Nema of netory or other plea	ce)	TULY 25 2	0c. Location -	City or Town, Stete
			4 □ Donation 5 □ Other (Specify)	l'a	AVVi	EW CKE	MATORY	2000 1	SALTE	o. MD.
Dali	pemit. Pe Departmen Important: any injury ance.		21. Signature of Funeral Service Licens	10 0	0 22	. Name and Addre	ss of Fecility	2829 H	UDSO,	U 5T.
	401 44		Thomas	Skarde	4 0	KAKDA	F.H.	BALTIN	JORE,	MD 21224
8			23a. Part1. Enter the disease of compl shock, or heert feilure that only or	cations that caused the de- ne cause on each line.	Do not ent	er the mode of dyir	ig, such es cerdiac	or respiretory erres	it,	Approximate fntervet Between Onset and Death
ŀ	Physician /Medical		Immedieta Ceuse (Finel		-1	01.	1. th	Mels 9	1	150
i	Examiner		diseasa or condition resulting in deeth)		en of		war	109 9	Come	1 DAy
Щ		Je		00010	(or as e conseq	Line i	Well-			44
	and and I-trensi	Examiner	Sequentially list conditions,	Due to	(or es a conseq			- 8 14 1 -		7
5	be executed ician and bunel-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	w	1	Bl	+D Me	elles,		10 7.
00/00	certificate be exe nding physician a use as the buriel-	edical	Ceuse (Diseese or injury that initiated events resulting in death) Lest	Due 10	or as a conseq	uance of):			34.5	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nding puse as	NMe.		I						
9	thet the death led by the atter detached for	Physicia	Pert tl. Other efgniffcant conditions con	tributing to death but not re	sulting in the u	nderlying ceuse giv	en in Pert t.			stribute to the cause of death? 3 Probably 4 Unknown
	s thet	by P						10 10	ZCI NO	3 Probably 4 Dirkhown
necolds,	lew requires thet the death as been signed by the atte 2 should be detached for	Completed						24e. Wes en perform	eutopsy ed?	24b. Were eutopsy findings eveilable prior to completion of ceuse of death?
2	0 - 7	ршс						1 ☐ Yes	2 12 No	1 Yes 2 No
	certificate	0	25. Wes cese refarred to medical				26 Place of Dec	eth (Check only one		10 163 20 140
ח אוומו		10 8	exeminer?	lospitet: 1 Inpatient 2	☐ ER/Outpatier	at 3 DOA Oth	or:	lome 5 Tesider		er (Specify)
2	er this		27. Mannar of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of			28d. Describe how		
DIVISION	eth. e: Aft	atlo	1 ☑Netural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 16a)	injury		Yes 2 □ No			
2	er de recto	Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury - At building, etc. (Spec	home, ferm, str	eet, factory, office		28f. Location (Stre City or Town,		er or Rurel Route Number,
3	ta safe led in Did	Ce								
	To the Hospital or Attending Pl within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funere	edical		lician: To the best of my kr ner: On the basis of exemir end menner steted.						
	To the comp	ž	29b. Signeture and title of certifier	1	/	29c. Licens			d. Data signed	(Month, Dey, Year)
	3		1	n)		1422		1. 2	-8,4000
	N. V		30. Name end eddress of person who co	mpleted ceuse of deeth (Ite	em 23e) (Type,	Print) 22.	3 EAS	TERN I	BL Va	13ALTO. Md.21221
H	Stat Registra	6	31. Date filled (Month, Day, Year) AUG 0 8 2000	32. Registrer's Sign	nature Soc	nks		,,		
			AUG U U LUUU	/	//					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 24935

	Certificate of Death		Reg. No.	500
T - 12	Decedent's Name (First, Middle, Last)	2. Dete of De		3. Time of Death
Physician	Virginia Mae Wunder	Augus	t 5, 2000	
/Medical Examiner		wn, or Location of Deat		
LAdiminer	1918 Victory Drive. Arbut	tus	Baltimo	ore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		rth 9. B	irthplace (State or Foreign Country)
Director	212.28.1473 1 M 2 TF 70 Yrs. Months Days Hours	Min. (Month, Do	. 1930 Ba	ountry)
7	Usual Residence of Decedent	12	, 2000, 20	TOTMOTE, III
ylan M M	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Man To	MD Baltimore Arbutus			1 ☐ Yes 2 ☐ No
or 28e-1 s be notified Director	10e. Street end Number 10f. Zip Code		10g. Citizen of What (Country?
			USA	
Sam mas 2	1918 Victory Drive. 21227 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Original Control of the Control of Hispenic Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Co	gin? (Specify Yes or No		nerican Indien,
her death or here 23s siner must	Armed Forces? If Yes, specify Cuban, Mexican 1 Never Merried 2 Married 1 Yes 2 No	, Puerto Rican, etc.)	Black, Wi	nite, etc.
by B	If Yes, Give 1 □ Yes 2 □ No Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify: W	hite
	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	
ygiene. ver then *netur rt, the Medical Completed	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	of working	TOD. KING OF DUSINGS	Samoustry
Ban B	Elementary/Secondery (0-12) College (1-4or 5+) ACCOUNTAINT		A.G. Pa	rrott Co.
	12	r's Name (First, Middle		
dod ever				
To afte			lia Judge	
1 1 1 1	19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number 19b) 19b. Meiling Add			
27 m 27	Linda Hayward- Daughter 1912 Victory Dri	ve. Arbu	tus, MD 2	1227
9 9	20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other pleca)	Dete	20c. Location - City	or Town, State
No. of Street	1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Chesapeake Crem. In	c.8/9/00	Beltsvil	le. MD
Trans.	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility	у		
8118	May K. marshall Gary 1. Kaufm	an Fun'l	Home@Mea	dowridge Me
	Pk. Inc. 7250 W	ashungtor	Blvd.El	kridge, MD
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiec or respiratory	errest, 21075	Approximate Interval Between
iysician	N / 7. (1 / 1		- 1	Onset end Deeth
Medical caminer	tommediate Cause (Final disease or condition Pulmonary Metas faces (RES)	peratory &	orline	1.5 ym
	timmediate Cause (Final disease or condition resulting in death) a. Pulmonay Metasfaces (RES) Due to (or as e-ponsequence of):			,
in and ial-transit Examiner	Breat Cines			6 ym
cian and burial-transit al Examir	Sequentially list conditions. Due to (or as a consequence of):			
E X	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): C. Due to (or as a consequence of):			
physician as the buria edical E	that initiated events Due to (or es a consequence of):			1
da se	resulting in death) Last			
use as	d			
attend Jorus Clan		nos Did	lashinana waa asaalhi	do so the access of death?
d by the attend etached for us Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.			ite to the cause of death?
		10	1488 3 No 3	Probably 4 Unknown
page 2 should be de Completed by P		0.4- 14/	241	b. Were eutopsy findings
should should			s en eutopsy 241 ormed?	eveilable prior to completion of cause
has by			0.200	of death?
page page		10	Yes 2 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Was case referred to medical 26 Place	of Deeth (Check only	one)	
To B	examiner? Hospital: Other:	A	idenca 6 ☐Other (S	necify)
	27. Menner of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury et		how injury occurred	, con 5 /
al Director: After to all Director: After to all by the funeral Certification:	M 10 Voc 201			
tor: A	3 Suicide 6 Could not be		(Street and Number or	Rural Route Number
Direct d in by	determined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)		own, Stete)	nural noute rulliber,
2 0				
To the Funeral Completely filled Medical Ce	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal			
To the Funeral Completely filled	and manner steted.			
To the com	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
_	Wan Capatertul Mas 02435	6	Aug 8	2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm. C. WATERFIELD MD STAGNES Concer	0.	101	
N	Um. C. WATERFIELD MD StAgnes Concel	inte 100	Bold Mr	/21220
	31. Date filed (Month Day, Year) / 32. Registrar's Signature		2006 7	-11
State	AUG 0 8 2000 Benever & Some			

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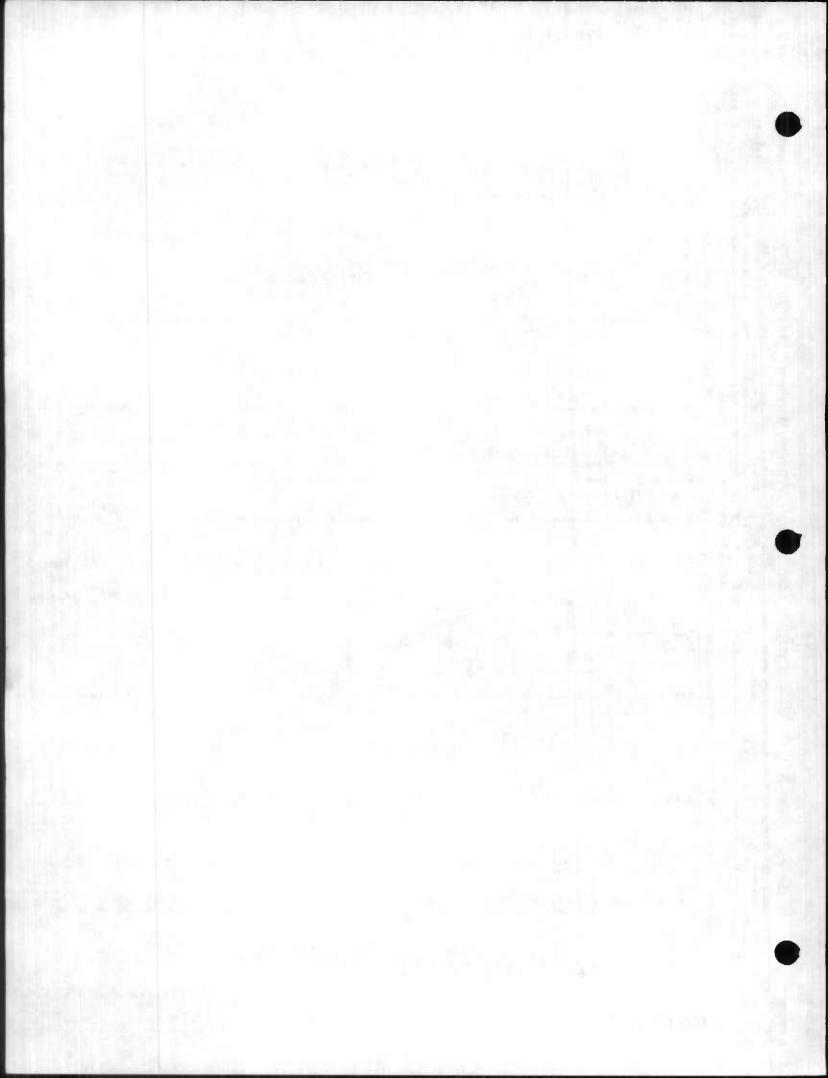
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** Aug. 4, 2000 Albert Edward Willey 11:30 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) **Examiner** Anne Arundel Linthicum 704 1/2 Hammonds Ferry Road If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1 M 2 □ F 76 Director 216.16.9564 July 2, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County Herne 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 704 1/2 Hammonds Ferry Road 21090 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus 1 XYes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3√CWidowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Route Manager Coca Cola Company 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nd Mental marked o Pages 1 and 2 should be Edward Willey Olga Evans 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) # nt of Health or If Item 27 is Diane Willey/Daughter 704 1/2 Hammonds Ferry Rd. Linthicum, MD 21090 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 XBuriet 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Pk | 8/8 Elkridge, MD 22. Name and Address of Fecility Gary L. Kaufman Funeral Home 21. Signature of Funeral Service Licenses 20013 7250 Washington Blvd. Elkridge, MD 21075 23e. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** fmmediete Cause (Finel disease or condition resulting in deeth) /Medical Myocudial Examiner Due to (or es e consequenca of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760 Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ of Vital Records, page 2 should be 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Wes an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician; funerel director, 25. Wes cese referred to medicel examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred 27. Manger of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury et Work? Division 1. Neturel 5 Pending Injury after death. Director: Aft 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifler 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of contili 30. Name and eddress of perser who completed cause of death (Item 23a) (Type, Print Datt 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

UG 0 8 2000



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 2000 Month Evelyn Anna Aug. 4, 8:40AM 4e Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Gilchrist Center If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. Nov. 22, 1 Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 1 M 2 F 89 Yrs. 214-01-5781 1910 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 300 International Cir. Apt. 344 21030 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A Office Clerk Petrleum Production 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James V. Cernik May Dunphy 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia R. Coughlin/Friend 39 Culmore Court Timonium, MD 21093 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State Aug. 5 Chesapeake Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Monse 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23e. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death)

Physician /Medical Examiner

The law requires that the death certificate be execut

been signed by t should be detact

certificate has been si irector, page 2 should

apital or Attending Physician: 1 hours after death.
neral Director: After this certifical y filled in by the funeral director, p

p

Completed

Be

Medical Certification: To

Box 68760,

Division of Vital Records.

Physician:

Physician

/Medical

Examiner

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Physician/Medical Examiner

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were autopsy tindings evailable prior to completion of cause ot death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 05p(CC Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? 1 Maturat 2 Accident 5 Panding investigation 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Pate signed (Month, Day, Year) 29c. License number 29b. Signeture and little of all

To the Hospital within 24 hours a To the Funeral Completely filled

DHMH 16 Rev 6/95

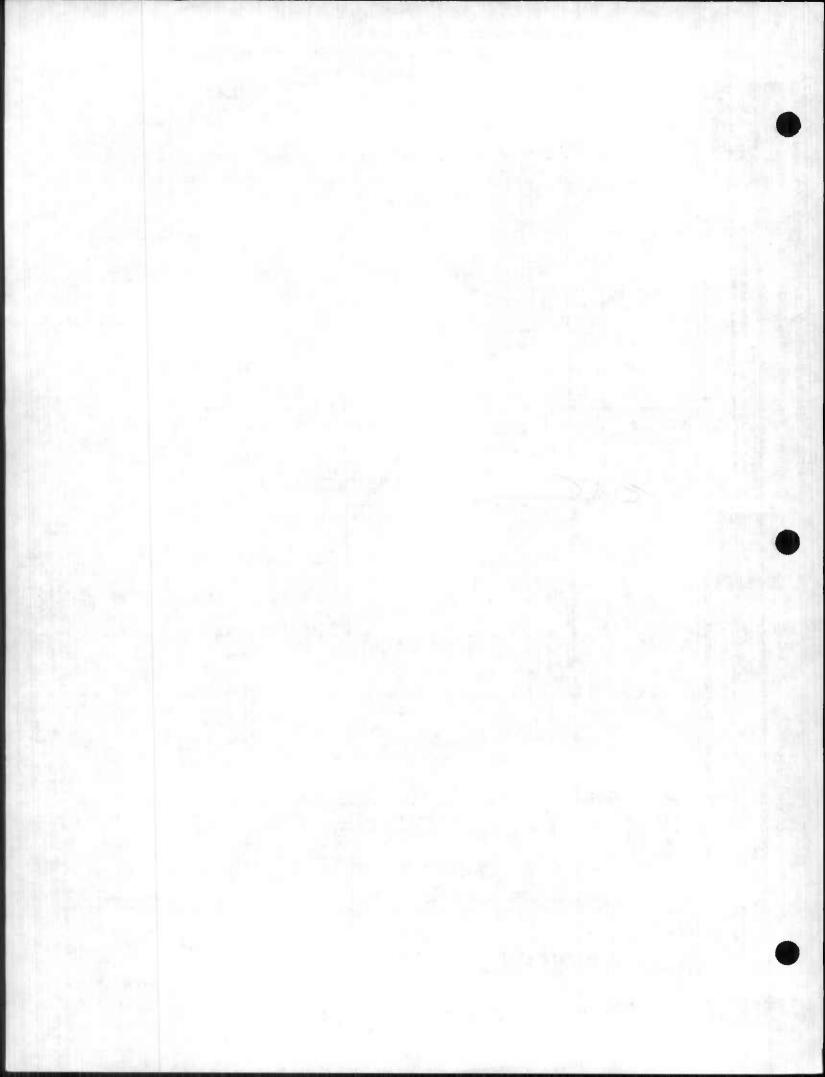
State Registrar

31. Date filed (MAN) G

GBIM 32. Registrar's Signature

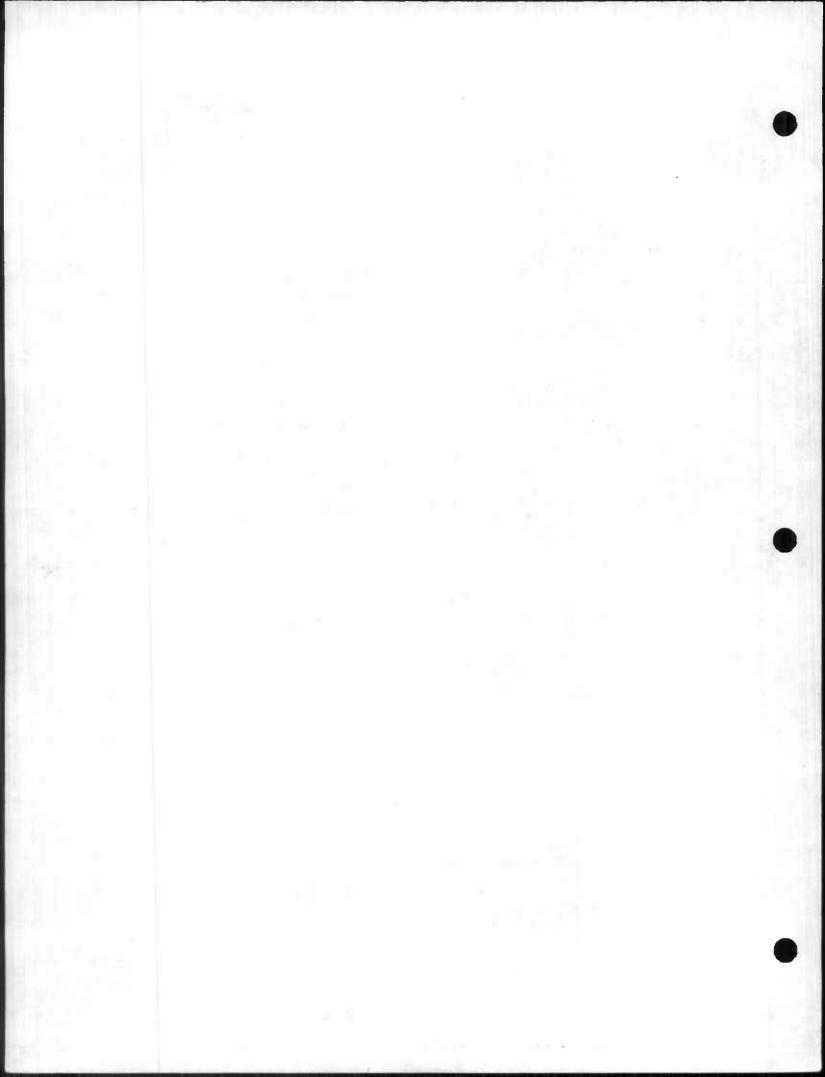
who completed cause of deeth (Hern 23a) (Type, Print)

V. Charles St. Balto and 6701



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Physicia: /Medica	_	1. Decedent's Nem		NE	ELLIE	M W	ITKUS		AU	Date of Dea Month	5 20	Year OOO	3. Time of Death 230 pm
Examine		4a Facility Neme (Franklin	590	are Ho	spita			Rose	wn, or Location	2	Ba	1+11	nore
Funeral Director		5. Social Security N 241-20-7 Usual Residence of	7601	6. Sex 1 □ M 2X F	7. Age (In yrs	ALC: A COLUMN TO SERVICE AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND A	Months Day		Min. (pate of Birt Month, Da g • 16	y, Year) 1921	9. Birthp Court Nor	lace (State or Foreign try) thCarolina
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urs after dee	by Funeral	11. Marital Status 1 Never Marr 3 Widowed		Armed F	3€ No	U,S. 13.	Wes Decedent of If Yes, specify Cu	ban, Mexican	gin? (Specify I, Puerto Ricar	Yes or No- n, etc.)		e - Americ ck, White, : W	
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end 2 si salth end n 27 is n				us / husi	band		ling Address (Street) O N Marl						Code)
0 0 - 1		20e. Method of Dis 1 Buriel 2	position	3 □Removel from	20b. Stete	Plece of Disp cemetery, cre	osition (Name of ematory or other pi	lece)		ete	20c. Location -	City or To	
pemit. Pag Department Important: I sny injury o		21. Signature of Fu	unerel Service I	icensee	00	7	22. Name end Add Connell	ress of Fecility Y Fune	ral Ho	me of			
the burners	Physician/Medical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list confirm any, leeding to incausa. Entar Undecuse (Disease or that initiated event resulting in death)	onditions, nmediate srlying injury s Last		Due to	or es a conse	quence of): be produce of): Hear-	neum t Fa		e			ne week
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tal or Attanding P is after death. at Director: After led in by the funer.	cer unice	3 ☐ Suicide 4 ☐ Homicida	6 ☐ Could n datarmi	ned Zoa. Place	of Injury - At I ing, atc. (Spec	nome, farm, si	treet, factory, office	9		Location (5 City or Tox	Street end Numb vn, Stata)	er or Rura	I Route Number,
Hospi 4 hou Funer tely fil	BOICE	29a. Certifier (Check only one)	1 Contifyin	Physician: To the examiner: On the b end men	be tof my kn asyl of examin ger teted.	owledge, deal ation and/or in	nvestigation, in my	opinion, daat	d place, end o	lua to the (cause(s) and ma dete end plece,	annar as si end due to	ated. tha cause(s)
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5	1	30. Name and addr DR Dan T	ran 9	who completed cause	se of deeth (Ite	m 23a) (Type quare	Print) Drive	Baltir	more	Mas	yland	210	237
State Registrar	,	31. Date filed (Mon	th, Day, Year)	32. F	legistrar's Sign	ature			r				
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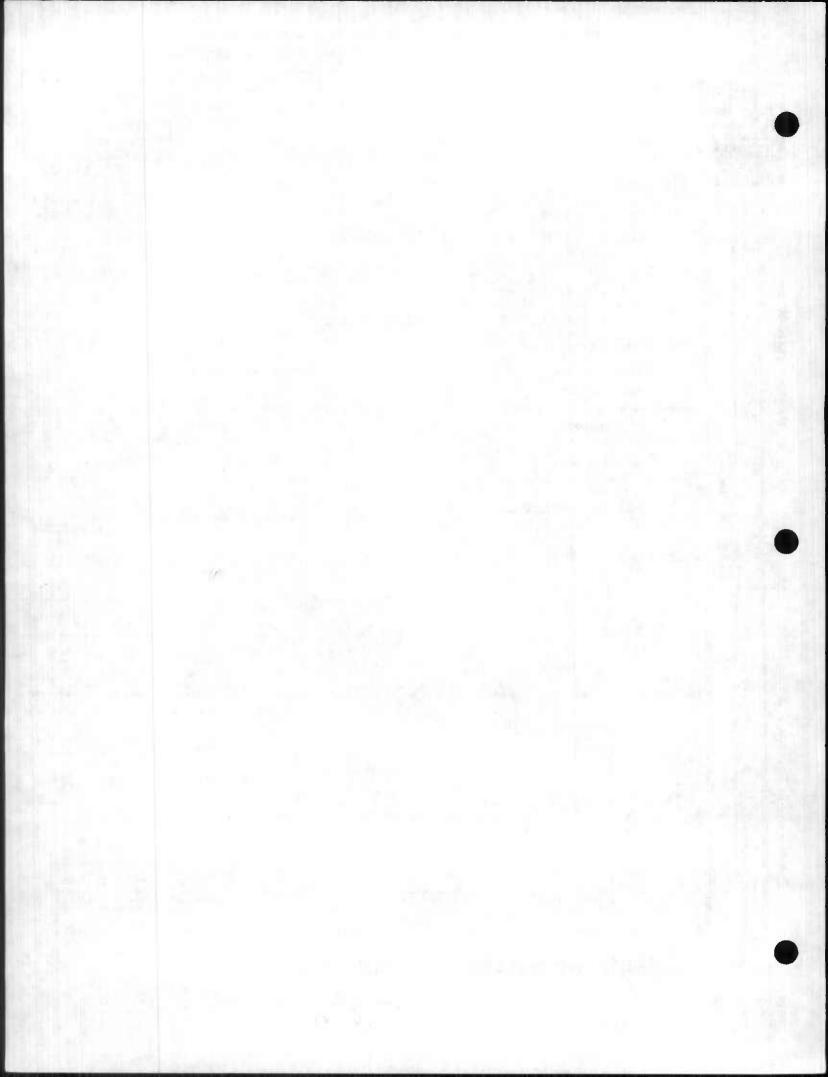
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	Decedent'a Neme (First, Middle, Last)	or maryland	Certificate of			g. No.	0 2	4939
Physician /Medical		ELVIN F	WIDOMSKI		AUGUST	^{Day} 200	O O	8:25am
Examiner	4a Fecility Neme (If not Institution, give street and 6349 Basket Switc			4b. City, Town, or Lo	ocation of Deeth	4c. County of		+0.5
Funeral Director	5. Social Security Number 213-09-7366 Sex 2D M 2D F	7. Age (In yrs. las	t birthdey) If Under 1 Yeer Yrs. Months Deys	Newark If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Oct. 31		9. Birthpiac Country Mary	e (Stete or Foreign Land
faryland I show ed.at	Usuel Residence of Decedent 10a. Stete 10b. County MD Worchester	10c. City, 7	Fown or Location	wark				Inside City Limits 1 Yes * No
h with the Ma Sa or 28e-f s at be notified al Director	10e. Street and Number 6349 Basket Switch	Road	10f. Zip Code	21841	10	g. Citizen of W	het Country	7
020 our after death v ex, or fees 23 Examiner munt by Funeral	1 Never Married 2 Merried 1 Yes,	eccedent Ever in U,S. Forces? es 2X No Give or Detes:	13. Was Decedent of H If Yes, apecify Cube	lispenic Origin? (Sp en, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American c, White, etc. White	
Maryland 21215-0020 d 2 should be filled within 72 hours at th and Mental Hygiens. 7 is marked other then "natural, or traumetic event, the Medical Exam To Be Completed by R		a (1-4or 5+)	16a. Decedent's Usuel Occup (Give kind of work dona life. DO NOT use retired Longshoreman	ation during most of work d)		6b. Kind of Bus		ade Assn.
D Hand	8th 17. Father's Neme (First, Middle, Last)		20119011011011	18. Mothar's Nam	a (First, Middle, M		-	100 115511
flanc	Paul Widomski			Fra	nces Lip	inski		
and and and and and and and and and and	19a. Informent's Neme/Reletionship (Type, Print)		19b. Meiling Address (Street	and Number or Rur	al Routa Number,	City or Town,	Stata, Zip Co	ide)
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altimore, mil. Pages 1 ar partment of Hea cortent: If Nem.? Y Injury or other 26.	20e. Method of Diaposition 1 ঐBurial 2 ☐ Cremetion 3 ☐ Removel fro 4 ☐ Donetion 5 ☐ Other (Specify)	om State	te of Disposition (Nama of letery, crematory or other please CrossPNCCemete	- 4- 4		Baltim		
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fice be executed fice be executed fice be executed by physician as the burial-transit edical Examiner	23e. Part1. Enter the disease, or complications the shock, or heart feiture. List only ple cause of limited cause of limited the cause of limited the cause of condition rasulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury the Initialed events resulting in death) Last	Alzhei Due to (or e Curon au	news Doney s e consequence of):				Ör	tervet Between nset end Death
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me	Part II. Other significant conditions contributing to	o deeth but not resulti	ng in the underlying cause giv	en in Pert I.			tribute to th	ne cause of death?
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To the Hospital or Attending Patthin 24 hours after death. To the Funeral Director: After templetely filled in by the funeral Medical Certification:	e □ Could not be	ece of Injury - At hom- itding, atc. (Specify)	a, farm, street, fectory, office		28f. Location (Str. City or Town	reet end Number, State)	er or Rurel R	oute Number,
Hospi 24 hour Funer tely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the and m	the best of my knowle a besis of exemination renner stated.	edga, death occurred at the tin n end/or investigation, in my o	ma, data and place, ppinion, death occur	and dua to the ca red at the time, de	use(s) and ma ata end place, e	nnar as state and due to th	ed. a cause(s)
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00-4422-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene PAIGE Certificate of Death WATSON 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 06, 2000 19:52 PM Paige Gregory Watson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner JOHN HOPKINS BAYVIEW BALTIMORE If Under 1 Year | If Undar 24 Hrs. Birthplace (Stete or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1☑M 2□F Yrs. 64 Director 212-32-5575 1-6-1936 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Baltimore Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 South 48th Street Funeral 21222 USA Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 12. Was Dacedant Ever In U.S. Armed Forces? Race - Amarican Indian, Black, White, etc. 1 ⊠ Yes 2 □ No Navy If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter City of Baltimore 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middle, Last) Mental should be is marked o Joseph E. Watson Edith Pindell 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 Department of Health a Important: If New 27 is any Injury or other training ance. 17 Glasshouse Garth, Baltimore, Maryland 21236
ce of Disposition (Name of Date 20c. Location - City or Town, State Ralph Watson Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 8/11/2000 Baltimore, Maryland Holly Hills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr., Funeral Home 21. Signature of Funeral Service Licen-263 South Conkling Street, Baltimore, Maryland purcued larea 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated expenses or Injury Due to (or as a consequence of): and Box 68760, that initiated events resulting in death) Last Dua to (or as a consequence of): es the 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? deteched P.O. 1 Yes 2 No 3 Probably 4 Onknown 3 signed λq of Vital Records, 90 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Be Completed performed? has funeral director, pege 2 1 □ Yas 2 □ No 1 Yes certificate al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, pe 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1€ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To . Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 4 Homicide Hospital 24 hours a Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) Medical 29a Certifier and manner stated. To the To the To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie OCME AUGUST 07, 2000

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DHMH 16 Rev 6/95

State Registrar AUG 0 8 2000

31. Date filed (Month, Day, Year)

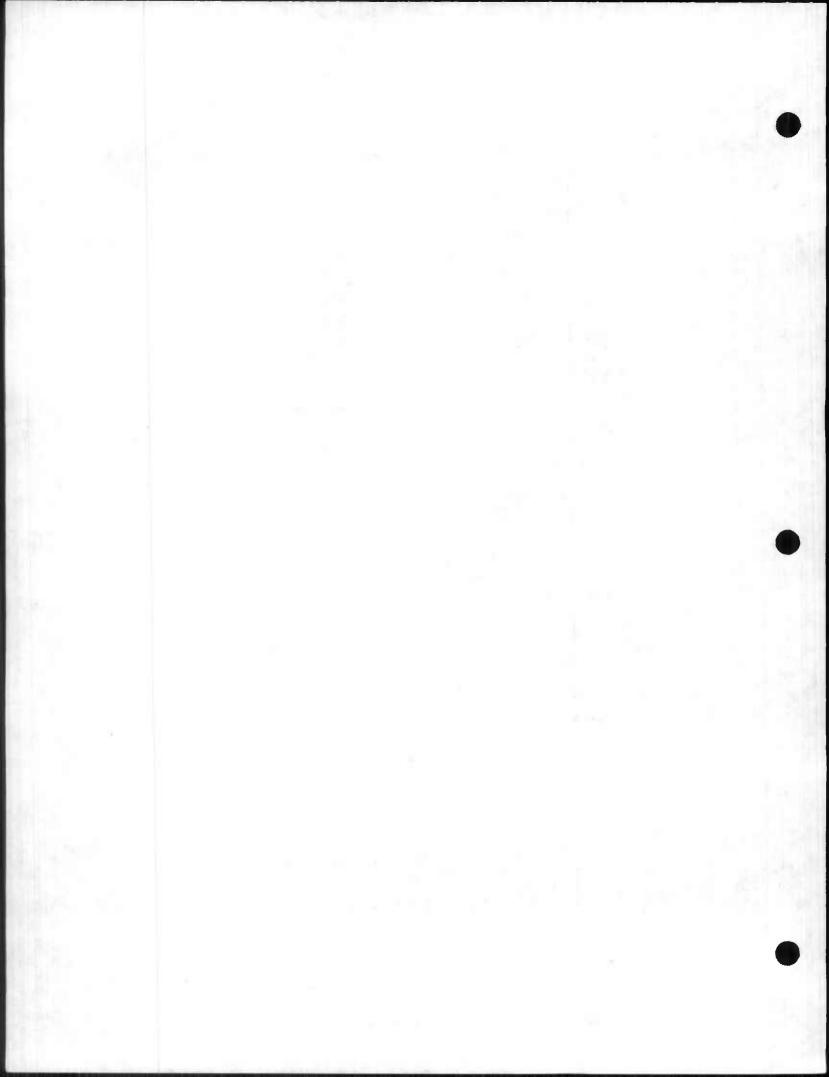
32. Registra

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Server & Signature Sports.

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physic /Med		Mary Cla	ire Weaver	r		1-2036		176	Augu		2000	073
Exami		ST A.	If not institution, giva	111				4b. City, Town, or		ath 4c. Coun	y of Death	
Funeral Director		5. Social Security 219-20-8	Number 6. Se	alth car ex 7. Ag	e (In yrs. la 73		f Undar 1 Yaar Months Days	If Under 24 Hrs		Sirth Sear)	9. Birthplac Country Mary la	ca (Stata or Ford
, DIICOLD.		Usual Rasidence o			T							
larylar strow	50	10e. Stata MD	10b. County Howard			Town or Local					10d	Inside City Lin
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5 22	by Funeral	11. Marital Status 1 Nevar Marr 3 Widowed	ried 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 2 1 H Yas, Giva Yaar or Datas:			s Dacedant of I as, specify Cub Yas 2 No	Hispanic Origin? (Sean, Maxican, Puar Specify:	Specify Yas or Note Rican, atc.)	BI	ce - Amarican ack, Whita, ato fy: White	
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2 strange			ame/Ralationship (T ver - Hust					tand Number or A t Hill D		ber, City or Town		
nit. Pages 1 and strment of Health orbant: If them 27 injury or other tr			position Cremation 3 0 5 0thar (Specify		Cel		ory or other pla	eterans	Data 8/10/00		- City or Town	
permit. Pag Department Important: I any Injury o		10	the disease of compart failure. Listionly of	addy,		59 16.	30 Edmo	ndson Av	enue Ca	tonsvill	e, Md	21228
Physician /Medical Examiner	Į	Immediata Causa disaasa or condition resulting in death)	(Final	a. 54BB	UR		em o				0	itérval Batweer Insat and Deatl
A 00/00, ertificate be axecuted sing physician and se as the burial-transit	Medical Examiner	Sequentially list co if any, laading to in cause. Enter Unde Causa (Disaasa or that initiated events rasulting in death)	s Last	b		as a consequa						
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or Attending I after death. Director: After Jin by the funar	Certification:	2 Accident 3 Suicida 4 Homicide	investigation 6 Could not be determined		ury - At hon c. (Specify)	na, farm, straai	M 1	Yas 2□No		(Street and Nun own, State)	bar or Aural F	Routa Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funar	edical Ce	29a. Cartifiar (Check only one)		sician: To the best of	f axamination							
2 5 2 5	Med	29b. Signatura	Hillio of a state of	and mannar sta	E(OU.		29c. Lican	sa number		29d. Data sign	ed (Month, Da	ıy, Year)
o the		1/6	The C				mo	5434	3	August	7,6	2000
To the To the Company									-	1	1	
To the within common co		30. Name and addr	rass of person who o	omplated causa of d			nt)	105 000	A ATOM	Aug 10	Arriw	2000 2122 2122

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 24942 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Month Vee **Physician** 4b. City, Town, or Location of Death 1:03 pm Mary Louise Wilson 2000 /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Billimore City Hornital 1 Ballening sunai If Under 1 Year | If Undar 24 Hrs. 8. Date Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1□M 2☑F 167-22-8220 73 Yrs. 11 May Pennsylvania Director Usuet Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. fnside City Limits 1 ☐ Yas 2 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1115 McAdoo Avenue Nerma 23a 21228 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. hopenn as then 1 ☐ Never Married 2 ☐ Married ò 1 Yes 2 No Specify: Specify: White by 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Bookkeeper Scheckells Bookkeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) marked of James Witt Josephine Novak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) repartment of Health reportant: If Item 27 Linda Wilson - Daughter 1115 McAdoo Avenue Catonsville, Md 21228 20b. Pleca of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State ö Meadowridge Memorial Park 8/8/00 Elkridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Home 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue Catonsville, MD 21228 23e. Pert1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Final disaase or condition resulting in deeth) /Medical Lancer Examiner Due to (or es a consequence of): Examine The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadieta cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest use es the bunal-trar Due to (or es e consequence of): 68760 Physician/Medical Due to (or es e consequence of): Box (P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the causa of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown yd bengis þ Records, 8 24b. Were eutopsy findings eveileble prior to completion of cause of death? page 2 should Completed 24e. Was en eutopsy certificate has 1 Yes 2 No 1 Yes of Vital Physician: 25. Wes case referred to medical examiner? edical Certification: To Be 26. Plece of Deeth (Check only one) 1 Yes 2X No Hospitef: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1. Natural 28e. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending invastigetion death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - Al home, ferm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as steled.

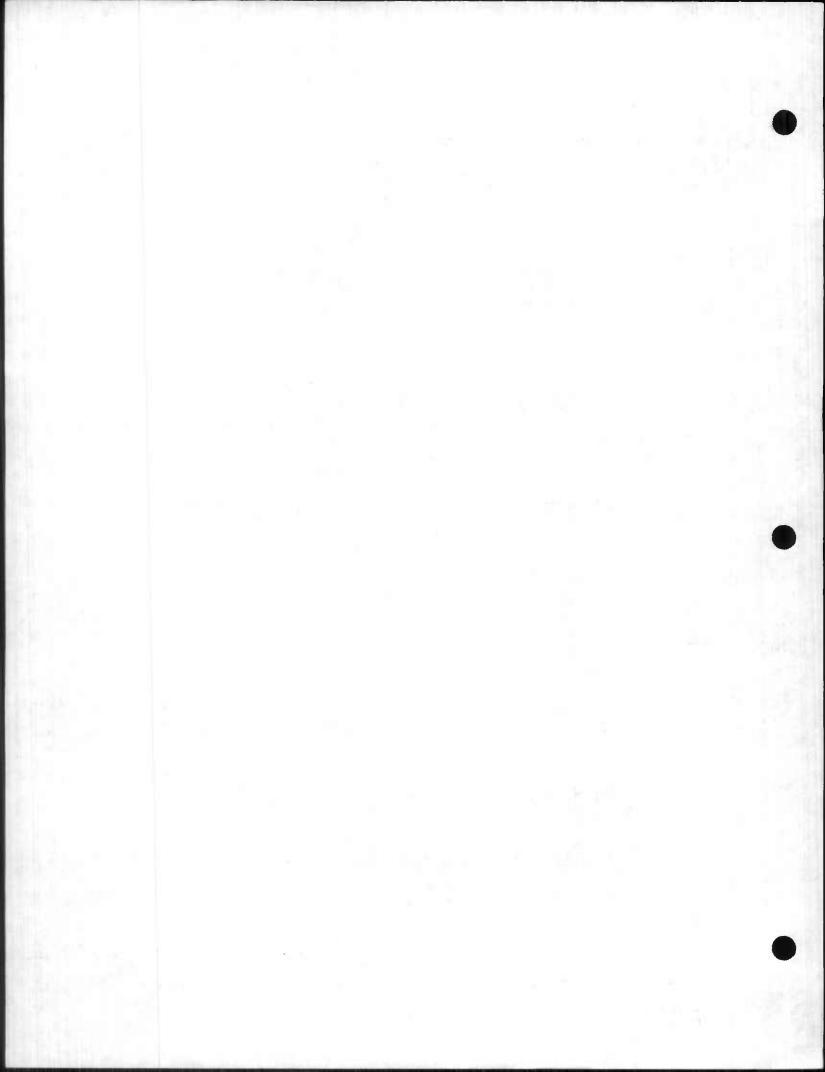
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier pletely within 2 To the 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end the Control 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hospital, 2401 W. Beluederg and CARLOS 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

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Registrar

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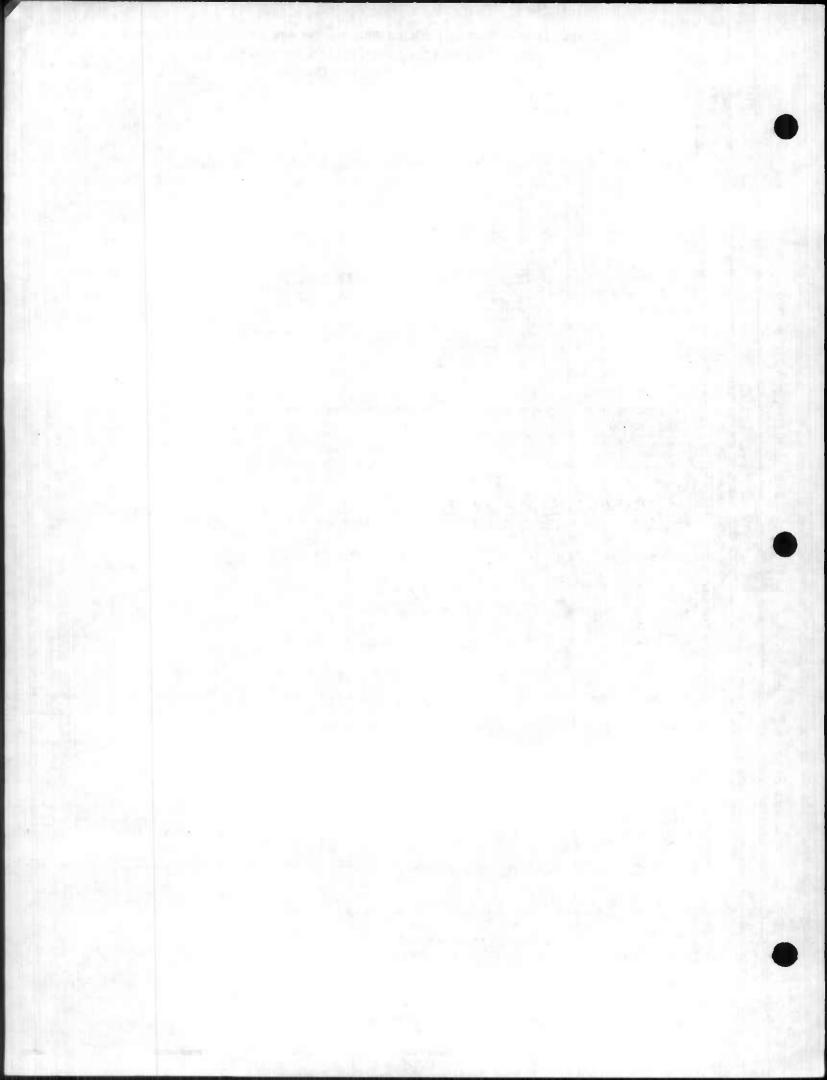


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State of Maryland / Department of Health and Mental Hygiene

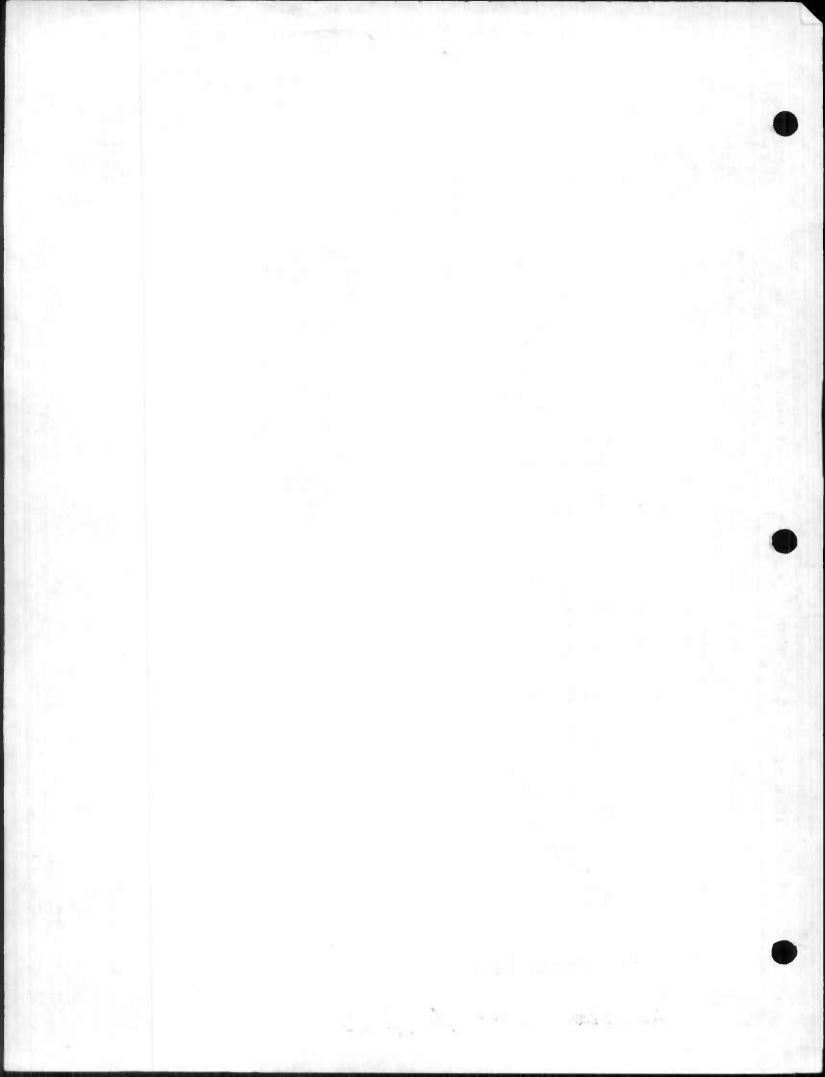
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				Cei	tificate o	of Death		Reg. No.		Lan 8 0 1 0
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	hysician /Medical	CAROLI	NE WE	ELSH			8	5	2000	7:15 p m
	xaminer	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deat	4c. County	of Death	
		Catonsville Com	mons			Catonsvi	11e	Balt	imore	
Fu	ineral	Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)	If Under 1 Ye Months Day		8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	lace (State or Foreign
Dir	ector	213-32-2832 Usuat Residence of Decedent	74X 01	Yrs.			11 8	3 1918	New	York
Pug	ž	10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Maryl	ada i									1 ☐ Yes 2 No
the state of	be nout at a Director	Md Baltimo	re Ca	tonsvil	10f. Zip Cod	0		10g. Citizen of \	What Cour	itry?
	r tems 23s or 28s-f s increment be routed Funeral Director	815 N. Winters	Lane		21228			J.S.A.		
death	ner man	11. Marital Status	12. Was Decedent Ever In	U,S. 13.		of Hispanic Origin? (Stuban, Mexican, Puerl			a - Americ	
, b	or he miner	1 Never Married 2 Married	Armed Forces?		Yes, specify C		o Hican, etc.)		ck, White,	atc.
5-0020 72 hours effer	9 6		If Yes, Give Year or Dates:		ILI Yes ZLI	чо Ѕреспу:		Specify Whi	te	
Maryland 21215-0020 at 2 should be filed within 72 hours eft to and Mental Hygiene.	d other than "natural", event, the Wedcel E. Be Completed by	15. Decedent's I		16a. Deced	ient's Usual Oci	cupation ne during most of wor tired)	king	16b. Kind of B	usiness/inc	dustry
aryland 2121 should be filed within nd Mental Hygiena.	i de	Elementary/Secondary (0-12)	College (1-4or 5+)			tired)				
1 2 v led v	S T O	8 17. Father's Name (First, Middle, Las	.al	Homer	naker	18. Mother's Nar	na (Eisat Middle	Own Hon		
laryland 212 2 ahould be filed with	a se								16)	
T d Mould	To	Pasquale D'An		10h Mailir	n Address (Str	JOSEPh1 eet end Number or Ri	ne Sal		State 7in	Code)
and 2 a saith an	t en	John Welsh	Son			ipe Raod C				
Te, N 1 and Health	other	20a. Method of Disposition		D. Place of Dispo	sition (Name of		Date	20c. Location	-	
noi ages	× × ×	1 Buriat 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, cremetery cremeters Cathe	natory or other	10	3/8/00	Raltimo	re 1	Maryland
Baltimore,	Important: If item 27 is marked other than any injury or other treumatic event, the Motice. To Be Comp	21. Signature of Funeral Service Lice				dress of Facility		Daltinc	16, 1	lary rand
Balt Permit. Departm	any is	A Coop !	bad 1	W:	itzke F	uneral Hom				21228
		23a. Party. Enter the disease, or co		eath Do not ent	30 Edmo	ondson Ave	. Catons	svilee, M	lary1	Approximate
Phys	icion	23a Part. Enter the disease, or co sheck, or heart failure. List on	doe cause on each line.	outh. Do not on	or the mode or	3,119, 0001, 00 001010	or roop natory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
2	ician dical	Immediate Cause (Final	TN	TRAC	RANI	AL HO	MORI	LAGE		Wes
Exar	niner	disease or condition resulting in death)	е	o (or as a consec					1	,,,,
1	je line	133 Half- DC (145)	D09 (i	LIT	V					YV.
I Records, P.O. Box 68760, The law requires that the death certificate be executed	physician and its the burial-trensit	Sequentially list conditions.	Due to	o (or as a conseq	uence of):					
0,0	List-t	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury							į	
68760,	the b	thet initiated events resulting in death) Last	C. Due to	o (or as a conseq	uence of):					
X 6	C		d							
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0 8	thed hed	Part II. Other significant conditions	contributing to death but not	resulting In the u	nderlying cause	given in Part I.	23b. Dld	tobacco uae co	ntribute to	o the cause of death?
P.O.	Ph detac		Dysphag	ie			10	Yes 2 No	3 Prol	bably 4 Unknown
Division of Vital Records, or Attanding Physician: The law requires the death.	cate has been signed by page 2 should be detacted.				10.3		24e Wee	an autopsy	24h W	ere autopsy findings
O. Deg	shoul etec							ormed?	avi	ailable prior to impletion of cause
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<u>_</u> =	ector, page Be Com			I William			10	Yes 200No	10	Yes 2 No
of Vita	rector, page Co	25. Was case referred to medical exeminer?	Hospital:	Li busana		0.11	ath (Check only			
Phys	T Gib	1 Yes 2 No 27. Manner of Death	1 Unpatient 2	28b. Time of	T 3LI DOA	4 Nursing I	1	dence 6 Oth		y)
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Div Phar	din din di	4 Homicide	building, efc. (Spe	ecify)			City or To	wn, Stete)		
epite	al C		hysician: To the best of my i							
To the Hospital within 24 hours a	To the Funeral Director: After completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exi	miner: On the basis of exam and manner stated.	inetion and/or in	estigation, in m	y opinion, deeth occu	irred at the time,	dete and plece,	and due to	the ceuse(s)
To the within	N Supplier	29b. Signature and title of certifier	AHE	مللم	29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
		Mulle	Purp.	nd.	1	36942	- 1	Augu	17	7, 2000
. (()	30. Name and address of person who	completed cause of death (item 23a) (Type,	Print)	01	TIME	10 ms	2	1220
1	7	B. TURAKHÍA	, MD 1009	fred	wick 1	36942 RD, RA		ر ب	-	-8
	State	31. Date filed (Month, Day, Year)	32. Registrar's Si		./					
B	tegistrar	AUG 0 8 7000	Dener 1	000	us					



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LINDA SUSAI	N WEISEL 23a,27 per me G789 11/1	State of Marylan		artment of H			giene (2	4944
411	1. Decedent's Neme (First, Middle, Las					2. Dete of De Month	ath Day	Year	3. Time of Death
Physician /Medical	Linda Susan Weise	e1				AUG.	6, 2000		10:05 AM
Examiner	4a Facility Name (If not institution, give	street and number)				or Location of Deat	4c. County	of Deeth	
	107 KENWOOD AVEN				CATONS			IMORE	
Funeral Director	5. Social Security Number 216-72-3714 6. Security Number 11	ex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year) 0, 1962	9. Birthpla Country Mary	ca (State or Foreign
p .	Usual Residence of Decedent	10- 6	ty, Town or Lo	antina				100	d Incide City Limite
anyla ahov	Maryland Baltimon		tonsvi					100	Inside City Limits □ Yes 2 ☑ No
vith the Mar n or 28s-f a be notified Director	10e. Street and Number						10g. Citizen ot W	that Count	
DIr DI	107 Kenwood Ave.			10f. Zip Code 2122	8		U.S.A.	mat Countr	,
eral eral	11, Marital Status	12. Was Decedent Ever in U	S 13 V			(Specify Yes or No		- America	Indian.
21215-0020 d within 72 hours after death with the Maryland glene. In than "natural", or items 23s or 28s-1 show than "natural", or items 23s or 28s-1 show the Wedest Examiner must be notified at 20mpleted by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:		f Yes, specify Cub 1 ☐ Yes 250 No	an, Mexican, Pu	erto Rican, etc.)		k, White, et	
22 ho	15. Decedent's Ed	lucation	16a. Deced	dent's Usual Occup	pation	undring.	16b. Kind of Bu	siness/Indu	stry
	(Specify only highest grade Elamentary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use ratire	during most or F	rorking			
	12		Plate	Maker			Print		
aryland 21215-0 should be filed within 72 ho nd Mental Hygiene. marked other than "nature umatic event, the Medical To Be Completed	17. Father's Name (First, Middle, Last)					lame (First, Middle		Θ)	
	Gerald Joseph Wes	isel			Anna	Mae Burg	et		
	19e. Intorment's Neme/Relationship (7	Type, Print)				Rural Route Numb			Code)
and and and and and and and and and and	Gerald J. Weisel				Ave. Ca	tonsvill			0
Baltimore, Marylis permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other treumatic page.	20a. Method of Disposition DEBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from Stete Me a	cemetery, crer	sition (Nama of matory or other pla ge Memor	ial Park	8-11-00	Elkrid		
Balt permit. Depart Import any inj pace.	21. Signature of Funeral Service Licen	660	OA	Name and Address F mbrose F 328 Sulp	uneral H	Home, Inc	Arbutus,	MD.	21227
	23a Fart1. Enter the disease, or composition of the shock, or heart tailure. List only	plications that caused the deal							Approximate nterval Between
G8760, fificate be assecuted [Medical Examiner st the burlal-transit edical Examiner fedical Examiner for the state of the	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b	HEART DIS	quence of):					
. Box 68 death certifica death certifica e attending pt ed for use as ti		d						1	
. 0 0 0	Pert II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying ceuse gi	iven in Part I.	23b. Did	tobacco use cor	ntribute to	the cause of death?
ords, P.O. Box 6i requires that the death certific een signed by the attending p hould be detached for use as eted by Physician/Mer						10	Yes 2 No	3 Probe	ably 40 Unknown
require been s should eted	The strip						an autopsy ormed?	com	a autopsy findings lable prior to pletion of cause aath?
I Rec						1/4	Yes 2□ No	de	Res 2□ No
Vital I olclen: The certificate inector, pag o Be Co	25. Was cese rafarred to medicel				26. Plece of I	Death (Check only	one)	/0	
	examiner? 1 Types 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA O				ar (Specify)	AT SCENE
0 5 5 5	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	t 28c. Inju		7	how injury occurr		AI SCENE
Division of the or attending P is after death. al Director: After the or in by the funare Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Special	ioma, term, str	reet, factory, office			(Street and Numb wn, State)	er or Rural	Routa Number,
To the Hospital within 24 hours a To the Funeral Completely filled	29a. Cartifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examine and manner stated.	owledga, daatt ation and/or In	n occurred et the t vestigation, in my	ime, data and pla opinion, deeth o	ace, and dua to the courred at the time,	cause(s) and ma date end place,	innar as sta and due to	ited. the cause(s)
vithin Fo the complete	29b. Signeture and title of certifier	111		29c. Licen	se number		29d. Date signer	d (Month, E	Pay, Year)
	The long	11.16 0	77 5	0	.C.M.E		AUG.	7, 20	00
	30. Name and address of person who	completed ceuse of deeth (Ital	m 23a) (Type.	Print)					
	31. Date tiled (Month, Day, Year)		11 Pen		, Baltin	ore, Mar	yland 21	201	
State Registrar	AUG 0 8 2000	Serens	6. 1	books					



MARSHALL YERBY Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 00-4328-510 UNKNOWNO AMEND ITEMS: #23 PART I, 27, 28a-b per Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

WR.

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dev **Physician** MARSHALL YERBY 02.2000 11:33 A.M. AUGUST /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE N/A 3626 WEST BELVEDERE AVENUE REAR | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | SEPT.13,1951 5. Sociel Security Number 6. Sex 12 M 2□ F Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Yrs. 48 **Director** 212-16-7200 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercises insist be notified at 1 Yes 2 No Directo MD. N/A BALTIMORE 10g. Citizen of Whet Country? 10e. Sfreaf end Number 10f. Zip Code U.S.A. Funerai 5123 ARBUTUS AVE Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Status filed within 72 hours after 1 Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOME. **IMPROVEMENT** 12th HOME IMPROVER 7 is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental MARSHALL P. YERBY MARY LOUISE TAYLOR 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 Ie eny Injury or other traubites. 3331 W.BELVEDERE AVE. BALTO.MD.21215 VANESSA R. YERBY-WIFE 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) Dete 20e. Method of Disposition 20c. Location - City or Town, Stete 128uriel 2 Cremetion 3 Removel from State Donetion 5 Other (Specify) MOUNT ZION CEMETERY 8/9/00 LANSDOWNE, MD. 22. Neme end Address of Fecility
LEWIS T.GWYNN FUNERAL HOME 21. Signeture of Funerel Service License Levenn Levenn T. GWYNN 4517 PARKHEIGHTS AVE. BALTO, MD. 21215-6393 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate fntervel Between Onset end Deeth **Physician** /Medical fmmedlete Cause (Finel diseese or condition resulting in deeth) ALCOHOL AND NARCOTIC INTOXICATION **Examiner** Due to (or as e consequence of): Physician/Medicai Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequença of) tha 23b. Did tobacco use contribute to the cause of death? P.0. been signed by the should be detached Pert If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown of Vital Records. Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 1 Yes 2 □ No Nes 2 No Physician: 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To SCENE this 28e. Dete of Injury
(Month, Dey Year)
Found:
8-2-0
28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

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28c. Injur 27. Menner of Death 28d. Describe how injury occurred To the Hospital or Attending Phythin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? Division 5 Panding investigation 1 Neturel UNKNOWN 1 Yes 2 XNo 2 Accident 3 Suicide 6 X Could not be determined 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 3626 W. BELVEDERE AVE. BALITMORE, M. 4 Homicide OTHER RESIDENCE 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) and manner stated. 29a. Certifier and menner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number O.C.M.E. AUGUST 03,2000 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Registrar

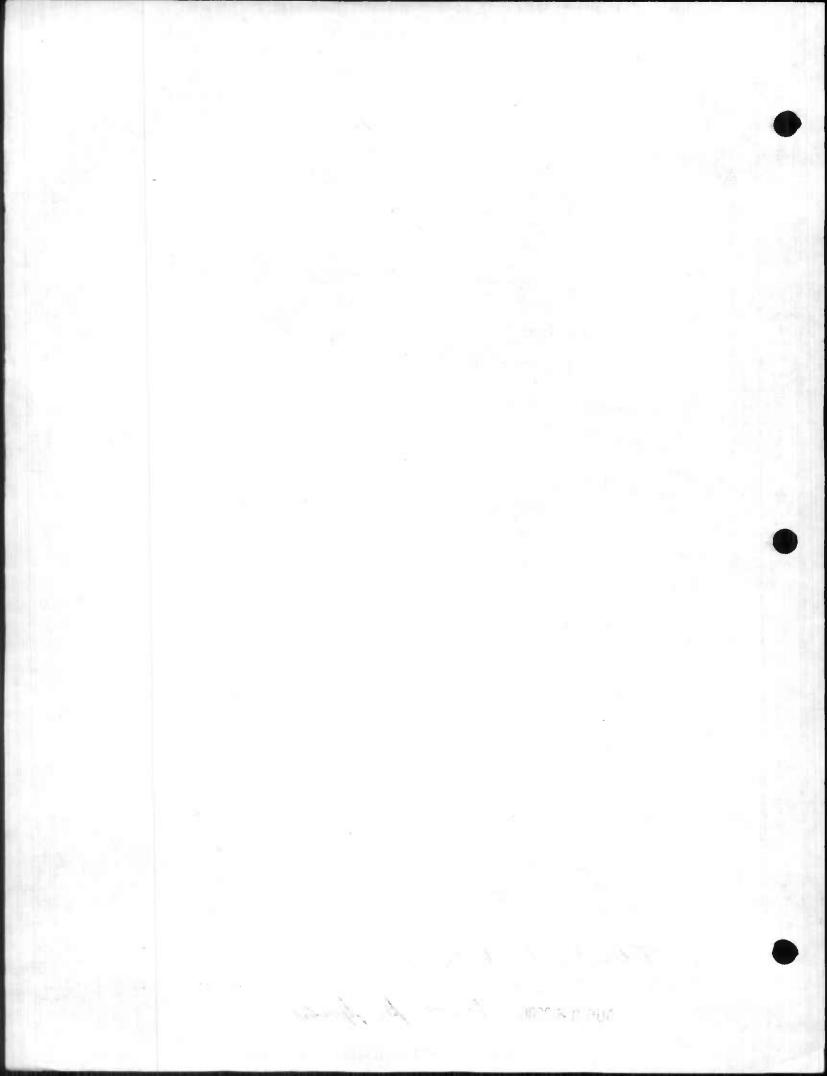
HEUDURE MIKE

AUG 0 8 2000

31. Dete filed (Month, Day, Year)

32. Regular's Signeture

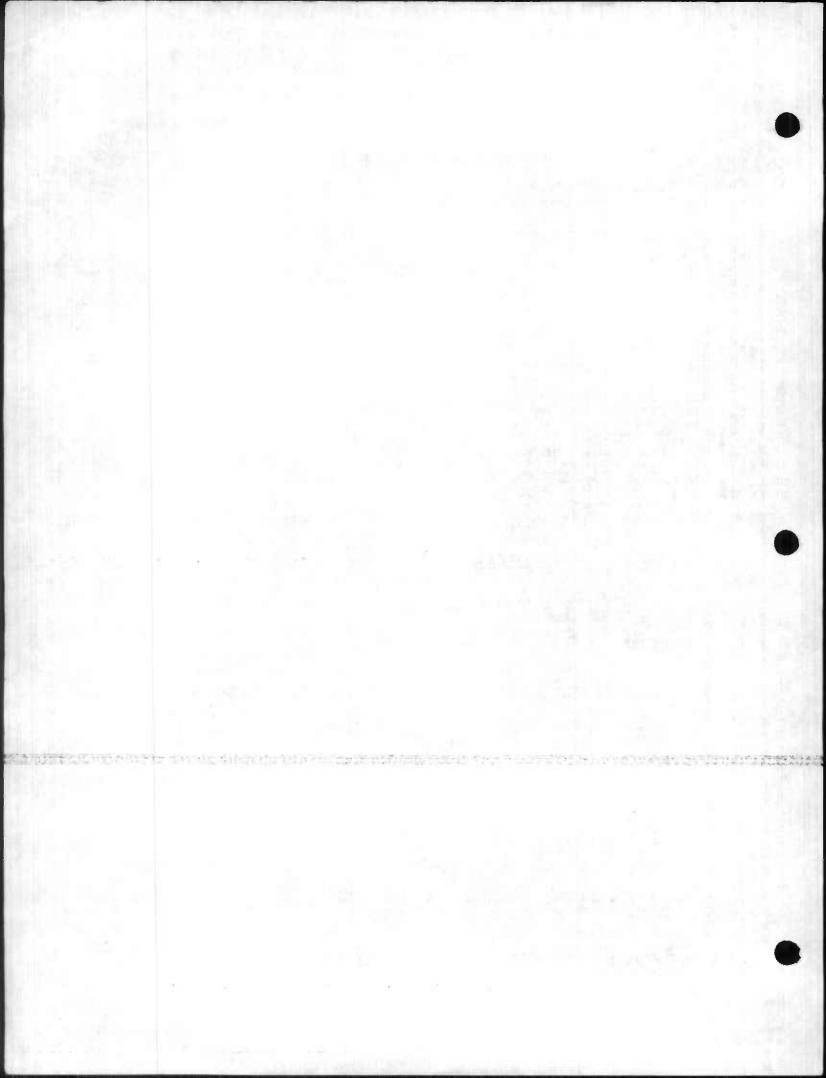
111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4e Facility Name (If not institution			11-60		4b	. City, To	wn, or Lo	cation of Deel				J.45 am
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Director	234-46-9698 Usual Residence of Decedent								may 9	17.	or	WESL	Virgini
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or 28a-f	10e. Streel and Number				10f. Zip Co	ode				10g. Cr	tizen of V	Vhat Coun	try?
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er tr	Marga H. Ander	son / Wife			Boston			Tak	oma Par	ck, l	MD :	20912	
五百名り	20e. Method of Disposition		20b. P	ace of Disp	osition (Neme metory or othe	of or place)		Dete	20c. L	ocation -	City or To	wn, State
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Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Year **Physician** Julia Virginia Anderson 20 2000 /Medical 4b. City. Town, or Location of De 4a Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 405 If Under 1 Year Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. Wast birthday) **Funeral** Deys Hours Months 216-18-7149 1□ M 2 F 91 Director Aug. 28, 1908 Virginia Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location d other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at MD Anne Arundel Pasadena Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 319 Light Street Avenue 21122 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Merital Status Bieck, White, etc. ☐ Yes 2 X No Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify Be Completed by 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. 4nderson, Elementery/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If flem 27 is marked oth any Injury or other treumatic svem access. (unknown) (unknown) 0 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 319 Light Street Avenue, Pasadena, Allen Anderson / son Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition July 24 20c. Location - City or Town, Stete 1 Buriat 2 Cemetion 3 Removel from State Elkridge, MD 5 Other (Specify 2000 Meadowridge Memorial Park Name and Address of Facility Barranco & Sons, Signature of Funerel Servica Lips Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 mirt1. Enter the disease, or combook, or heart failure. List only et caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, in each line. **Physician** Immediate Ceyse (Finel disease or condition resulting in deeth) /Medical Urosepsis Examiner Due to (or as a consequence of): Intracerebral hemonhag Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) and Malignancy Box 68760 physician of unknown Due to (or es e consequence of) the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Please Type or Print in Biack indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

The law requires that the death certificate be axec. Physician/Medical signed by the attending of be detached for use es Division of Vital Records. P.O. PV Completed 24a. Wes en autopsy performed? peeu this certificate Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Certification: To Impatient 2□ ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of After 5 Pending investigation 1 Netural 2 Accident death. t Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier edical (Check only one)

24b. Were autopsy tindings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No

3. Time of Death 8:30 pm

10d. Inside City Limits

White

Approximete tntervet Between Onset and Deeth

1 ☐ Yes 2 No

21122

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinton, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number 29d. Date signed (Month, Dey, Year) D0053514

2000 20

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) YOO. M.D. North Arundel Hwan

301 Hospital Drive, Glen Burnie, Maryland

State Registrar

31. Dete filed (Month, Day, Year) JUL 2 5 2000

29b. Signeture end title of certifier

32 Registrer's Signeture

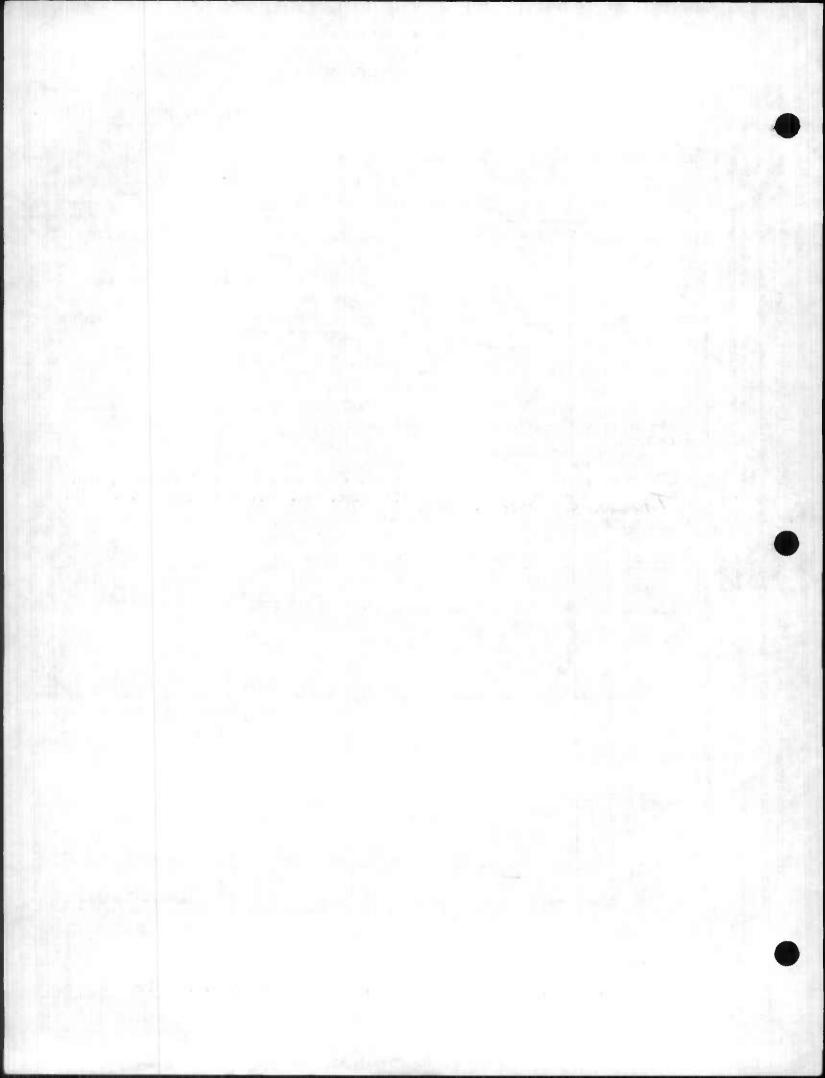
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AMEND: ITEMS: #10B-F G786 8-19-00 WR Continued Realth and Mental Hygiene *Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 26, 2000 2:55 AM. Moore Braverman Anne /Medical 4h City Town or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Brighten Gardens Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) Virginia 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2X F 577-62-3142 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State CHEVY CHASE Montgomery "natural", or items 23a or 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes -2 19 No Ann Arundel Gibson Island Funeral Directo 10e. Street and Number 5555 FRIENDSHIP BLVD. 10f. Zip Code 20815 10g. Citizen of What Country? 652 Stillwater Road 21056 U. S. A. filed within 72 hours after death Race - American Indian, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) parmit. Pages 1 and 2 should be file Department of Health and Mertiel Hy Important: if then 27 is marked othwany any Injury or other treumatic event BOBs. 17. Father's Name (First, Middle, Last) Be Bernard Moore Jones Helen Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) REbecca Frailey - Daughter Bethesda, MD 20816 5305 Cromwell Drive 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal Irom State 7/28/00 Richmond, Virginia Hollywood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee 5130 Wisc. Ave. NW., Washington, D.C. 20016 1-homas E. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Metastatic Cancer of Unknown 1° 6 Months Examiner Due to (or as a consequence of): Physician/Medical Examiner pital or Attending Physicien: The law requires that the death certificate be executed using a feeth.

veral Director: After this certificate has been signed by the attending physician and filled in by the funerel director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings Be Completed 24a. Wes en autopsy performed? evailable prior to completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 27. Manner of Deeth 28e. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred Certification: tnjury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

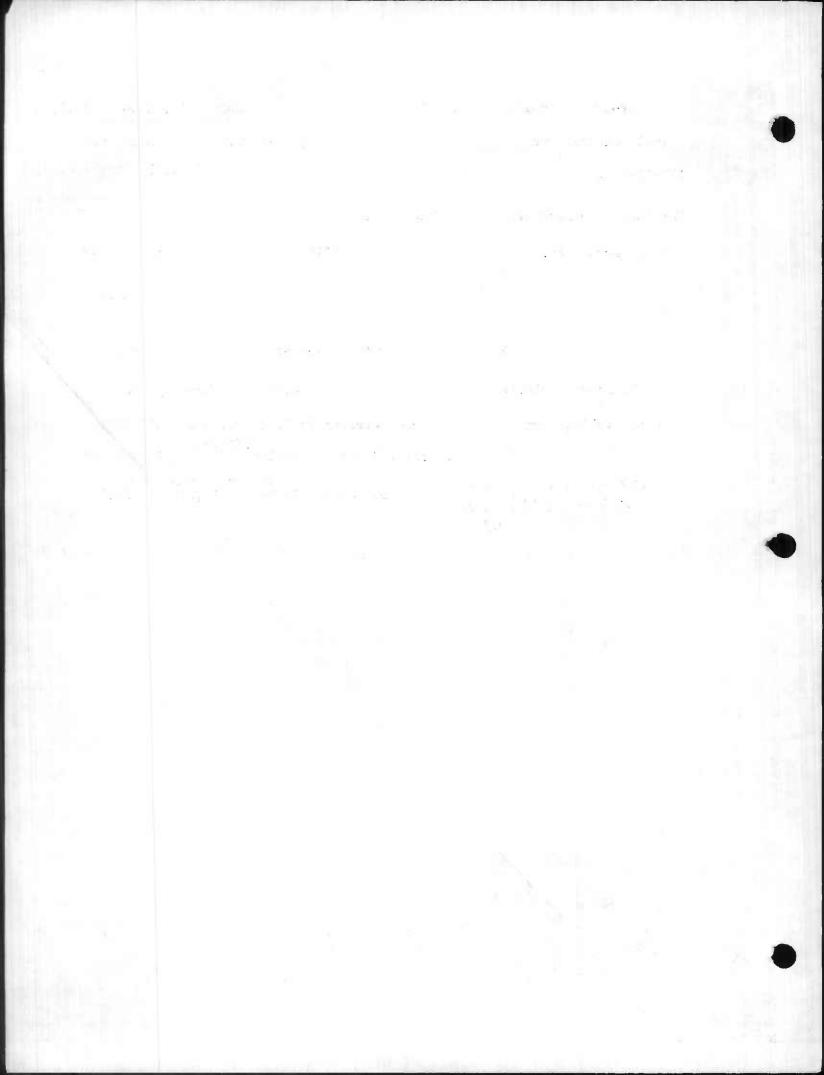
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29b. Signature and yall of ourt land 29c. License number 29d. Date signed (Month, Dey, Year) 11506 26, 2000 July 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, MD. 5401 Western Ave. NW., Washington, D.C. 20015-2998 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Yes **Physician** July Dorothy Belle Buckler. 19, 2000 11:30am /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7051 Carroll Ave Takoma Park Montgomery If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 10 1927 5. Social Security Number 7. Age (In vrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months 1 M 25 F Days 72 Washington, DQ Director 577-01-4902 Usual Residence of Decedent the Maryland 10e. State 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Exercises must be notified at Maryland Montgomery Takoma Park 1 N Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 7051 Carroll Ave 20912 United States Funeral death Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Inportant: if item 27 is marked other than "naturel", or item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3. Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondery (0-12) College (1-4or 5+) Office Manager Retail other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be John August Sobotka Clementia Dorothy Farr 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John E. Buckler/ Son 4038 Harrisville Road Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 07/31/00 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 0 Arlington, VA Arlington National Cemetery Injury o 22. Name and Address of Facility Takoma Funeral Home 21. Signetury of Funeral Service Licensee 254 Carroll St NW Washington, DC 20012 23a. Part1. Enter the diseese, or complicate shock, or heert falture. List only one complicate shocks are the complete shocks. Approximate Intervel Between Onset and Death the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** /Medical immediate Cause (Final cardiovascular disease disease or condition resulting in death) **Examiner** Examiner the daath certificate be executed bunal-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or inJury that initiated events resulting in death) Last and Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as e consequence of) use as guip ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 2 X No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed peen page 2 2 No 21 No 1 Yes 1 Yes certificate I or Attending Physician: after death. director, 25. Was case referred to medicat Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 10 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manger of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation Neturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI The Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical complately (Check only 29c. License number 15/19/16 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and eddress of person who completed cause Pite, PMB 348, Rock ville, omsko ville atricia 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State JUL 23 Registrar



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								Certific			inomal riy	Reg. No.	0 2	24950
	Physici	an	1. Decedent's Nam-	e (First, Middle, La	st)						2. Date of Dea	ath Day	Yaar	3. Time of Death
Ę	/Medic			ine M. Bu							July 21	2000		2:00am
	Examin	er	4a Facility Name (/	Carrier and the		ber)					Location of Death			
-	Funeral		5. Social Security N	icholson		Aga (In yrs	. last birth		der 1 Yaar		8. B. Data of Birt	Prince		rge's place (State or Foreign ntry)
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	yland		10a. State	10b. County		10c. C	ity, Town	or Location					1	0d. Inside City Limits
	e Mar	ctor	Maryland	Prince (George's		Hyat	tsvill	.e					1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Nur	mber				10f.	Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	eath v	Funeral	3513 N	icholson	Street 12. Was Deced	ent Evar in I	1S	13 Was De	2078		Specify Yes or No-	USA 14. Bac	e - Amario	can Indian,
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Baltimore,	교육관금.		21. Signature of Fu			bat	e or	22. Name	and Addra	ass of Facility				ng,Maryland
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Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai Certification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place o	f Injury - At I		m, street, fac	tory, office		28f. Location (S City or Tox		er or Run	al Route Number,
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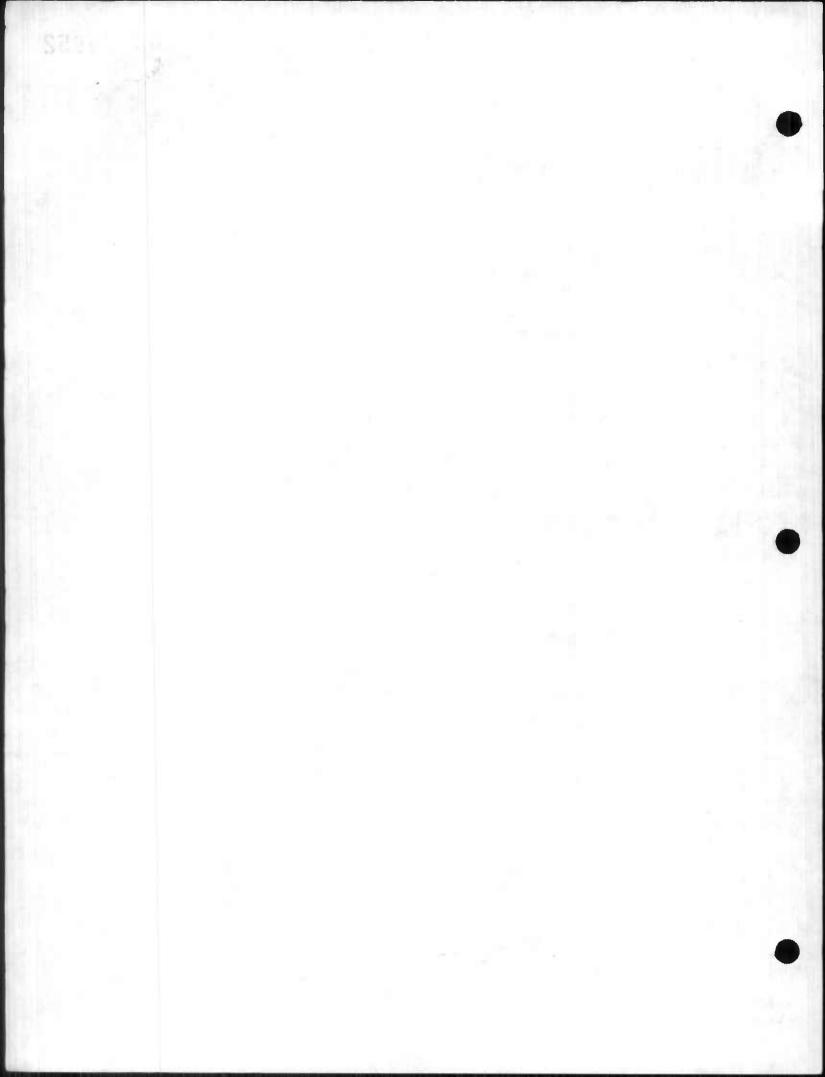
State of Maryland / Department of Health and Mental Hygiene 11 24951

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C 2 44 FU	19a. Informant's Name/Ralationship (T. ROBERT E. BAULSIR,	SR.HUSBAND	19b. Mailing Address (Str. 14303 GAINE	S AVENUE, R			
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State of Maryland / Department of Health and Mental Hygiene
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Physician	1. Decedent's Name (First, Middle, Last Bradley David		wman			2. Date of De Month	23, 2000 2000 2000 2000 2000 2000 2000 2	3. Time of Death 2320 PM	
/Medical Examiner	4a Facility Name (If not institution, give ROXBUR)				4b. City, Town, or L HAGERSTO	NWC	WASHIN		
Funeral Director	217 10 313 .	7. Age (In yrs. I. M 2 F 29		Inder 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da July 2		Birthplace (State or Foreig Country) ry Land	
ms 23s or 21s-f show crivat be notified at heral Director	Usual Residence of Decedent 10a. State Maryland Harford	10c. City Belo	r, Town or Location	n				10d. Inside City Limit: 1 ☐ Yes 2 🖾 No	
23a or 28a-f s at be notified al Director	10e. Street and Number 4405 Pulaski High	way		7. Zip Code 21017			10g. Citizen of What United Sta		
ar, or its Examine by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Decedent of H , specify Cuba /es 2 No	lispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, W Specify: W		
ygiene, natur r, the Medical Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			Usual Occup of work done OT use retired OTET	eation during most of work d)	sing	16b. Kind of Busine	ion Company	
ental Hyg kad other c event, I	17. Father's Name (First, Middle, Last) Bud Bowman				18. Mother's Nam Ernesti		Meiden Sumeme) Manley		
t Health and M ham 27 is mer other traumet	19a. Informant's Name/Relationship (7) Bud Bowman/ Fath		_				er, City or Town, State Mills, M		
0 = 5	20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Plane Che	ace of Disposition emetery, cremetor sapeake	(Name of y or other place Cremat	ory,Inc.7	Date 7/27/00	20c. Location - City Beltsville		
Department Important any Injury DDES	21. Signature of Funeral Service Licens Laura C. +	lardesty	CAFA 8717	Steph Green	en D. Loh Pastures	rmann F Drive	A. Baltimore	, MD 21286	
physician and street is the buriel-transit supported in the buriel-transit supported in the support of the supp	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or influry that Initiated events resulting in death) Last	Due to (or Due to (or	TIC INT as a consequence as a consequence as a consequence	e of):	TION				
		1.		2				1	
ach ach	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the underly	ying ceuse giv	en in Part I.			outs to the cause of dest	
ete has been sign page 2 should be						perfe	an autopsy 24 ormed?	b. Were autopsy findings available prior to completion of sause of death? 1 Pres 2 No	
is certific director	ILX res 2 No		ER/Outpatient 3	DOA		ome 5 Res	idence 6 Other (S	Specify) AT SCEN	
or Attainants after deeth. Director: After in by the fune	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Pending Investigation 6 Could not be determined		POUND: NO FOUND FO	Word 1 □	CELL	UNKN 28f. Location (City or To	Street and Number own, State)	CORRECTIO R, HAGERS	
within 24 hours within 24 hours completely filled	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medicat Exami	sician: To the best of my knowner: On the besis of examinat and manner stated.	vledge, death occion and/or investig	urred at the tingation, in my o	me, date and place opinion, death occu	and due to the	cause(s) and manne	r as stated. MD	
within To the compl	29b. Signature and title of certifier	tann	am,	29c. Licens	c.M.E		29d. Date signed (M	24, 2000	
	30. Name and appress of person who co	empleted ceuse of death (Item PES tance) 32. Registrar's Signal	11 Penn	Street	, Baltim	ore, Ma	ryland 212	201	



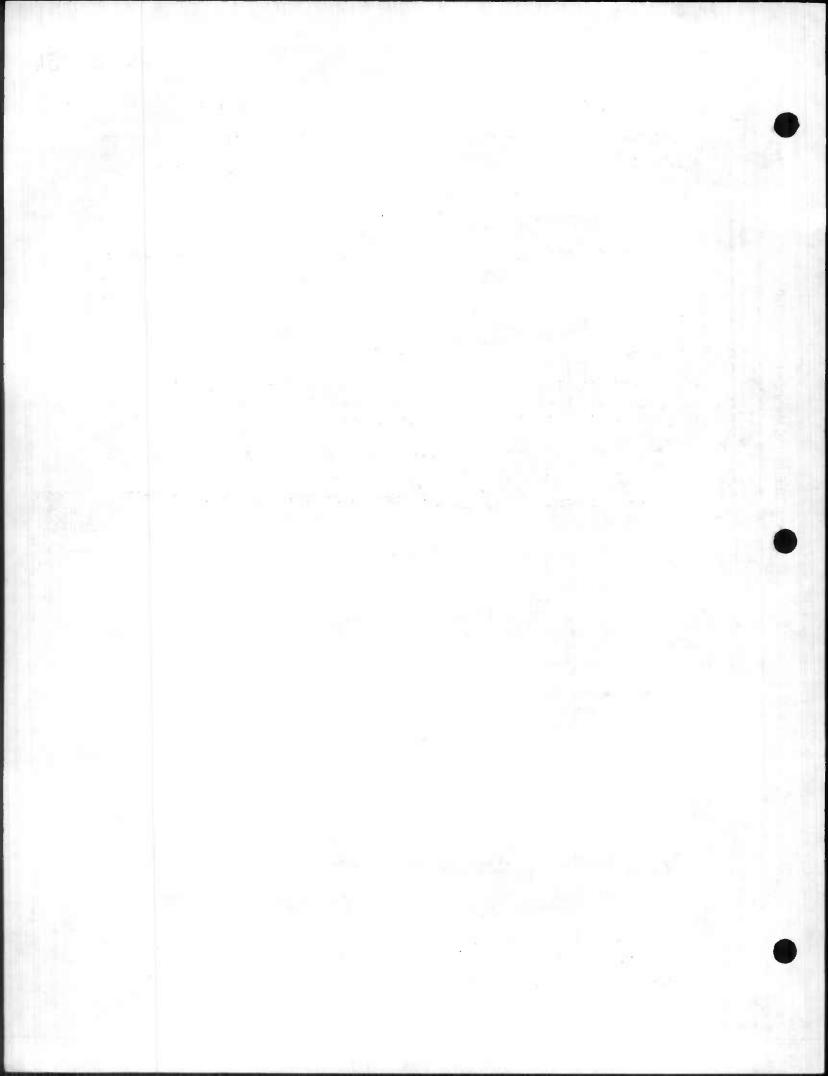
State of Maryland / Department of Health and Mental Hygiene 00 24953

				Ce	rtificate of	Death		Re	g. No.		
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-		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Yaa			Date of Birth	Anne		
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L	Director	Usual Rasidence of Decedant		70			10	ury 20	, 1930	wasii	., D.C.
	pus A.	10a. Stata 10b. County	10	c. City, Town or Lo	ocation						10d. Insida City Limits
	be filed within 72 hours after death with the Maryland nial hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Exercitive must be notified at Be Completed by Funeral Director	MD Anne Ar	undel	Annapo 1	is						1 Xyas 2 No
	or 2	10e. Streef and Number			10f. Zip Coda			10	g. Citizan of	What Cou	ntry?
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	daa daa	11. Marital Stafus	12. Was Decedant Eva Armed Forcas?		Was Decedant of	Hispanic Orig	in? (Specify	Yas or No-			cen Indian,
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21215-0020	ed within 72 ho ygiene. her than "natur. rt, the Medical.	15. Decedent's E		16a. Dece	dent's Usual Occi	upation	e	1	6b. Kind of B	usinass/In	dustry
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an	ad out	Timothy Hanlon				Vath	leen l	Полгом			
2	should be filed within and Mental Hygiene. I marked other than umatic event, the H	Timothy Hanlon	Torre Delet	400 04-05	- 4 -	1			0's as Talin	Ot-4- 7:	- O- d-)
Maryland	12 sho h and ls ma raum	19a. Informant's Name/Ralationship (ng Addrass (Stree						
	s 1 and 27 item 27 i	Edward J. Byrne			ilverwoo	d Circ			polis		21403
070	of T	20a. Mathod of Disposition 1 ABurial 2 Cramation 3		20b. Place of Dispo cematary, cra	osition (Nama of matory or other pl	(ace)		Data 2	Oc. Location -	City or T	own, Stata
E	Pagas nent of I int: If the iry or o	4 Donation 5 Other (Special		Hillcrest	Memoria	1 Gard	ens 7	-28-00	Annar	olis	, MD 21401
altimore	permit. Pages 1 and 2 should Department of Health and Mer Important: If them 27 is marke any injury or other traumatic page.	21. Signatura of Funaral Service Lice									Home, Inc.
Ö	Depa Impo any is	> Chron	Vouell								MD 21401
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that ceusad the	daath. Do not an	tar tha moda of dy	ring, such as o	cerdiac or re	spiratory arra	st,	1	Approximete Interval Batween
7	Physician	orosi, or main tanora. Cist only	one of the one and the contract.	1		-				1	Onsat and Death
	/Medical	Immediate Ceusa (Final	5	7 =	61	1				1	
п	Examiner	disaasa or condition rasulting in death)	a. <u>)e</u>	9) 10	Jho	CY		1		1	
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	0 0 0	Part II. Other eignificant conditions of	ontributing to death but n	ot rasulting in tha u	ndarlying ceusa g	ivan in Part I.		23b. Did tob	pacco uae ço	ntribute t	to the cause of death?
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Vital	Physician: The this certificate ral director, page To Be Co	25. Was cesa rafarred to medical axaminar?	Name of the second				of Deeth (C	check only one	1)		
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	Ing Ph. Aftar th funeral	27. Manner of Death	28a. Data of Injury (Month, Day Ye	28b. Time o	f 28c. Inj	ury at ork?	280	l. Dascribe hor	w injury occur	rred	
Division		2 ☐ Accident invastigation			M 1[☐Yas 2☐N	No				
Vis	after death. Director: A Lin by the f	3 ☐ Suicida 6 ☐ Could not b	288. Place of injury	At homa, farm, st	reat, factory, office	В	281.	Location (Str.		ber or Rur	ral Routa Number,
Ö	din din	4 D Floringide	building, atc. (5	эр <i>еспу)</i>				Chy or Town,	, Stata)		
	Hospital 24 hours Funeral staly filled	29a. Certifier Certifying Ph	ysician: To the best of m	v knowladga, daat	h occurred at tha	tima, data and	d place, and	dua to the car	usa(s) and m	annar as	statad.
	Ne Hosp n 24 hou Ne Fune pletaly fi		niner: On the basis of axi	amination and/or in	vastigetion, in my	opinion, daati	h occurred a	at tha tima, da	ta and place,	and dua	to the cause(s)
	To the Hospital or Attendible 24 hours after death To the Funeral Director: completaly filled in by the Medical Certifical	29b. Signature and site of certifier			29c Licer	nsa number		29	d. Data signe	d (Month	Day, Year)
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		Une !	MD H,	nee Y	v D.	771	OI		YILI	KS	2000
		30. Nama and address of person, who	completed cause of death	(Item 23a) (Type,	Print) A	Aimee Y	U. MD				
		64 F Kai	Sheet	- Ann	apolis	M	ID	214	101		
	State	31. Data filed (Month, Day, Year)	32. Registrar's	Signature	1						
	Registrar	1111 9 5 200	1 same	Ø.	400ck						

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State of Maryland / Department of Health and Mental Hygiene 00 21, 051.

						C	ertifica	te of	Death			Reg. No.	00	_	4904
	Discontinuo	1. Decedent's Nam	a (First, Middle, La	st)							2. Data of De Month	eath Day	Ve	ear :	3. Tima of Death
	Physiciar /Medica	Allia V.	Carris								July 2		00		4:00 p.m.
	Examine	4a Facility Nama (I							4b. City, To	wn, or L	ocation of Deat	h 4c. C	County of E	Death	
		Mediplex	of Monte	gamery V	<i>'</i> illage				Gaith		ourg	Mo	ntgar		
	Funeral Director	5. Social Security N 083-18-59		Sex IDM 25F	7. Age (In yrs. 89		y) If Under Months	Days		24 Hrs. Min.	8. Data of Bir (Month, De July 2	th Year) 6, 19	10 9.	Birthplac Country Greec	ce (Stete or Foreign CE
	Pu k	Usual Residence of	Decedent 10b. County		10c G	ty, Town or	Location	-						104	. Inside City Limits
	aho a		Montgom	21777		ither								100	Yas 2 No
	vith the Mar	10a, Street and Nu		EL Y	Ga	TUICI.		p Code				10g. Citize	on of Wha	t Country	
	23a or		tkins Mi	ll Road			20	0886				j.J.	SA .	:4.	
020	72 hours effect death with the Maryland naturel; or thems 23s or 28s-f show does Examine must be notified at	3 Widowed	ed 2 Married 4 Divorced	12. Was Dece Armed For 1 Yas If Yas, Give Yaar or Da	ces? 2 No	J,S. 1:	3. Was Deci If Yas, spi 1 Yes			gin? (Sp n, Puerto	ecify Yes or No Rican, atc.)	100	Black, V	White, atc	
5-0	n 72 hours naturel;	(Spec	15. Decedent's E			16a. Dec	edent's Usi	ual Occu	pation during mos	t of work	ina	16b. Kin	d of Busine	ass/Indus	itry
Maryland 21215-0020	di di	Elementary/Second 12th Gra	ndary (0-12)	College (1	4or 5+)	lifa	sewife	use retire	od)			Dom	estic		
b	tal Hyginal Hy	17. Father's Nama)					18. Mothe	r's Nem	e (First, Middle	, Maiden S	iumema)		
lai	Menta by Men		itsilaki						Penel	ope.	Samoth	raki			
any	and M	19a. Informant's Na		Type, Print)		19b. Ma	iling Addres	s (Stree	t and Numbe	er or Au	ral Route Numb	er, City or	Town, Ste	te, Zip Co	ode)
Σ	and 2 aith 127 i	Anthony C	arris	(son)		26 G	reenti	ree (Court,	Ft	Salong	a, NY	117	768	
Baltimore,	permit. Pages 1 and 2 should be filled w Department of Health and Mantal Hygies Important: if Itam 27 is marked other ti any Injury or other traumatic event, its angles.		osition Cremation 3 5 Other (Specif		Stata	Place of Discematary, co	rematory or	other pla		17	Data 7/25/00				, Stata
=======================================	ortan	21. Signature of Fu			0	011			ess of Facilit		/ 23/ 00				
ä	Ped drie	1	Leonge	- XX	Luce	The same	-						ckvil	le,	MD 20850
	Physician /Medical Examiner	23a. Part1. Enter the shock, or heat	Final		mer's 1		se							0	itarval Between
,00	rifficate be executed ng physician end a set the burlai-transit														
Box 68760,		resulting in death)		d	Dua to (d	or as a cons	equence of)	:							
	death e atter ed for u	Part II. Other signif	cant conditions	ontributing to de	ath but not ras	sulting in the	underlying	causa di	ven in Part I		23b. Did	tobacco u	se contril	bute to th	he cause of death?
P.0.	d by th		nsufficie									Yes 2			v
Records,	been signe ahouid be c	Anemia									24a. Was	an autops ormed?	y 2	availa	autopsy findings able prior to detion of cause
	3 20										10	Yas ZE	No	of dea	ath? ∕as 2□ No
VItal	ysicien: The last certificate his director, page	25. Was case refer	ed to medical						26. Place	of Dee	th (Check only	one)			
2	Physicien: this certific ral director, To Be	axaminer?	No	Hospitel: 1 Ir	patient 2	ER/Outpat	ient 3 🗆 C	OA Ot	her: X Nu	ırsing H	oma 5 Res	idence 6	Other (Specify)	
ion of	Attending Phirideath. setor: After thi by the funeral		5 Pending invastigation		f Injury n, Day Year)	28b. Time Injury	of M	28c. Inju Wo 1	ry at ork? Yas 2	No	28d. Describe	how injury	occurred		
Division	or Att	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28a. Place	of Injury - At h g, atc. (Speci	oma, larm,	street, lacto	ry, office			28f. Location (City or To	(Street and wn, State)	Number o	or Rural R	louta Number,
	Hospi 4 hours Funer taly fill	29a. Certifier (Check only one) 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the course of a samination and/or invastigation, in my opinion, death occurred at the time, or and mannar stated.													
	Within 2 To the comple	29b. Signature and title of certilier 29c. License number								29d. Data	signed (A	Aonth, Da	y, Year)		
	4	Dolux A Ball B30					3069	92			Jul	y 22,	200	00	
		30. Nama and addr						ove I	Road,	Rock	wille,	MD 2	0850		
	State	31. Data filed (Moni	h, Day, Year)	A.	gistrar's Sign	atura \mathcal{G}	do	ock	2						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Dale of Death **Physician** 6:20Pm SOOK Chana 22 hung 2000 July /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SILVER SPRING MONTGOMERY MANOR CARE NURSING HOME If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country)
 KOREA 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F Yrs. 578-74-5401 66 Director Usuel Residence of Decedent r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD. MONTGOMERY Bethesda 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code in Medical Examiner must be in 20814 4521 EAST WEST HWY. #1508 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify λq If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced ASIAN Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 ORGANIST MUSIC 7 is marked other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Falher's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Health end Mentel CHANG-DAE KYUNG-AE K. CHANG 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 a Department of Health er important: if item 27 is any injury or other trau YOUNG HO CHANG/BROTHER 15730 AMBIANCE DR., N. POTOMAC, MD. 20878 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removel from State 7/29/00 RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 21. Signature of Funeral Service Lia 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 rangelle -M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician tmmediate Cause (Finat disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thel initiated events resulting in death) Last Box 68760. the Due to (or es e consequence of) P.O. 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 250No 3 Probably 4 Unknown signed by þ Division of Vital Records. 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Be Completed this certificate has 90gd 1 ☐ Yes 2 5000 1 □ Yes 2 □ No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To To the Hospital or Attending Pr within 24 hours after deeth. To the Funeral Diractor: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending Investigation 1 (25 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide teritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4 May MD D43260 July 24, 2000 30. Name and eddress of person who completed cause of death (Hem 23a) (Type, Print)

Tenny y May MD 13952 Baltimore Aux Laurel MD 20707 Jenny 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JUL 25 sereva Sparker 2000 Registrar

There . Marie Carlo Col. Tr of response

State of Maryland / Department of Health and Mental Hygiene

24956

Physician /Medical **Examiner**

Funeral Director

28a-f show ò must be 23a thems r than "natural", or iten the Medical Examiner filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020 Pages 1 and 2 should be fill trainert of Health and Mental Hitant If them 27 is marked off Department of Health a Important: If them 27 is any Injury or other trau once.

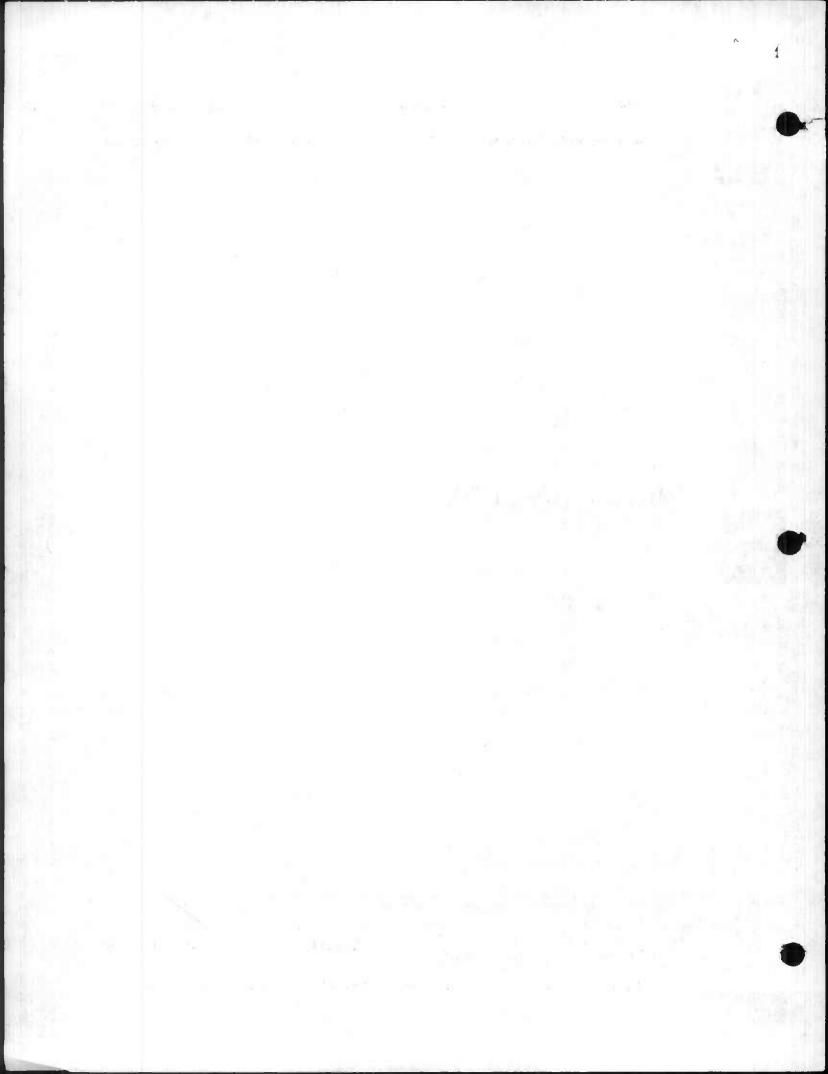
Physician /Medical **Examiner**

The law requires that the deeth certificate be executed pue use es the bunal-trer Box 68760. ettending physician for use es the buna signed by the elid be deteched for P.0. Division of Vital Records, peen certificate I or Attending Physician: after death.
Director: After this certifica director, funeral In by the within 24 hours aff To the Funeral Di completely filled It Hospital To the

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day 15, 2000 Coleman Sandra1 6:00 PM 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery If Under 1 Year 5. Social Security Number if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 8, 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1□M 2√2 F Months Days Hours Min. 578-78-5903 43 1956 Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 □ No Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 299 Hurley Avenue 20850 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒No Specify: by 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser 12 Private 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Be William Coleman 2 Rachel Booth 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Cheng (Brother-in-law) 12 Coldstream Court Boonsboro, MD 21713 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Weathersby Cemetery 7-22-00 Prentiss, MS 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Facilit Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, 22310 VA Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final a Cardiopulmonary Arrest disease or condition resulting in death) Due to (or as e consequence of): Examiner Multiorgan Failure Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Metastatic Glioblastoma Multiforme Physician/Medical Due to (or es e consequence of): Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 《☐Unknown þ Completed 24b. Were eutopsy findings eveileble prtor to completion of cause of death? 24e. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death Certification: 28a. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

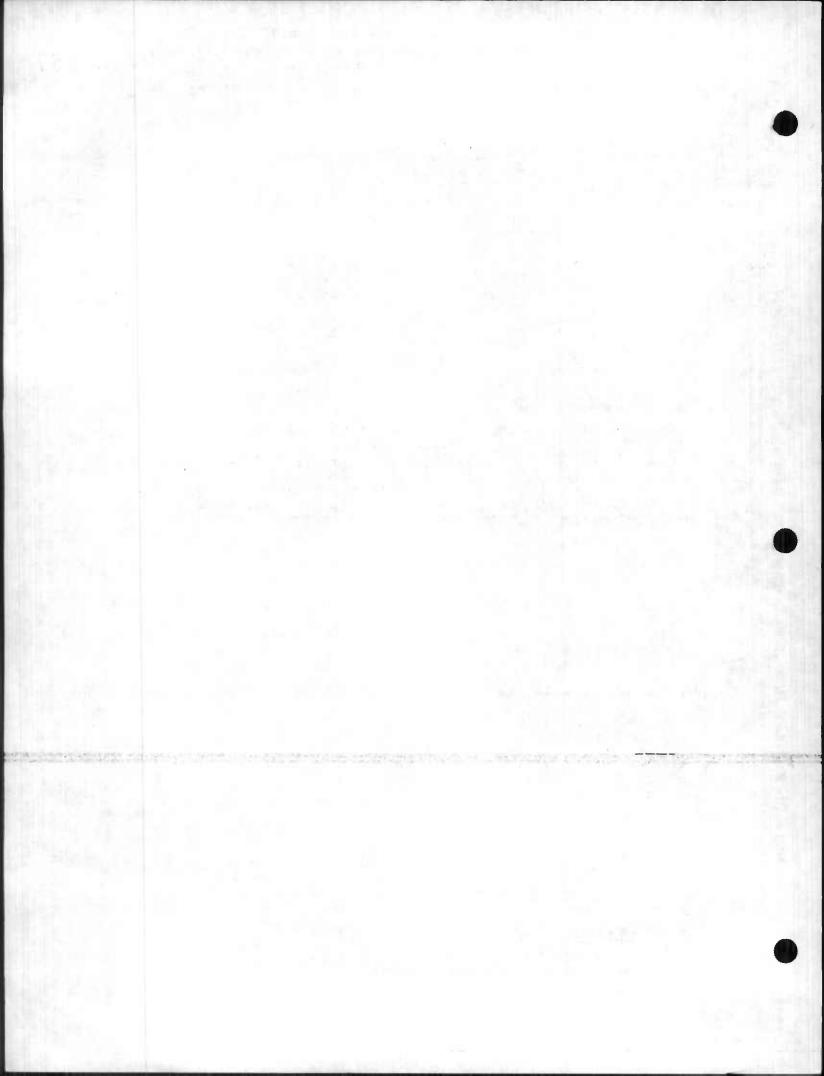
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D52261 July 17, 2000 30. Name and address of person who completed cause of death (flam 23e) (Type, Print) 1299 Lamberton Drive, Silver Spring, MD Alan R. Segal, M.D., 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State JUL 2 3 2000

Registrar



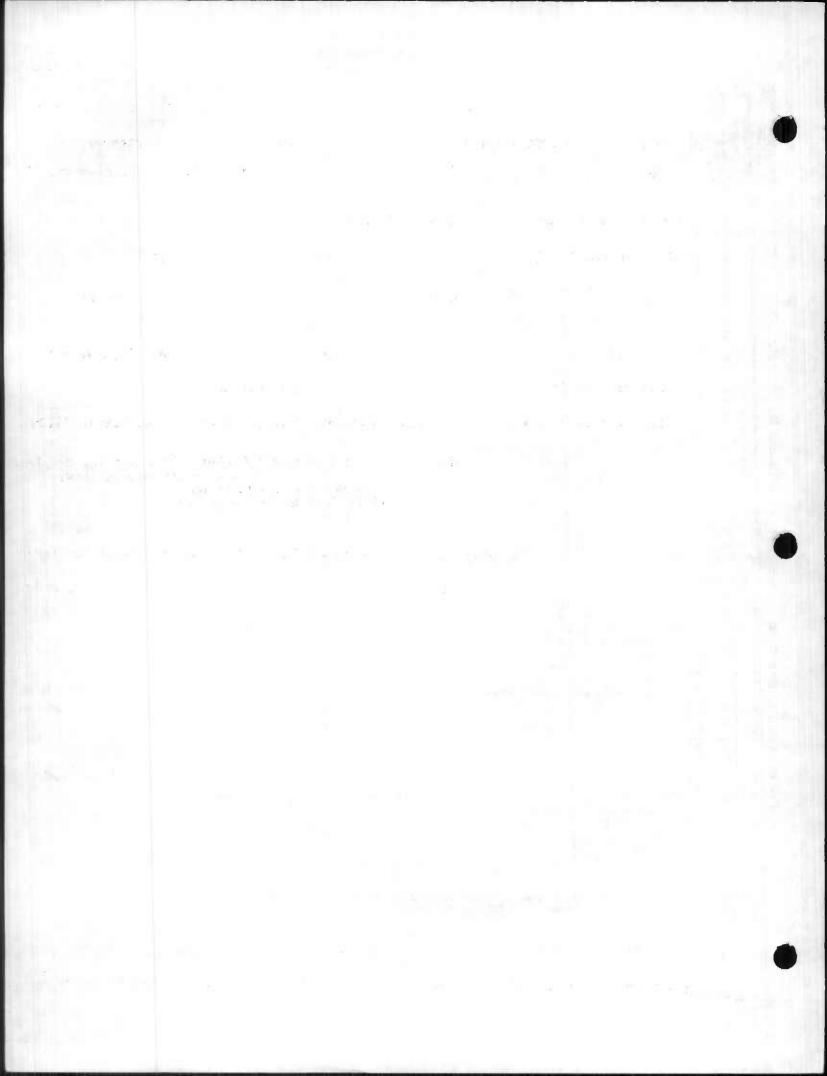
State of Maryland / Department of Health and Mental Hygiene 00 21,957

			Certificate of	f Death	Reg	g. No.	2490.7.
	1. Decedent's Neme (First, Middle, Last)	Migrate Sign	DESCRIPTION OF		2. Date of Death Month	Day Ye	3. Tima of Death
Physician /Medica Examine	Irene Marie Con			4b. City, Town, or Lo	July 21	2000 4c. County of D	12:05 am
Funeral	19005 Riverton Str		est birthday) If Under 1 Yee Yrs. Months Day		8. Date of Birth (Month, Day,) Mar 25,	Montgom (ear) 9.	Birthplace (State or Foreign Country)
Director	219-74-3266 Usual Residence of Decedent	94			mar 23,	1900 Ne	w York
No. of St.	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limita
and and and and and and and and and and	Maryland Montgomer	ry Olne	y				1 ☐ Yes 2X No
for death with the Maryis terns 23s or 28s-f short the most be notified at	10e. Street and Number 19005 Riverton Str	reet	10f. Zip Code 20832			g. Citizan of What	Country?
0 5 58 5		12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Detes:		Hispenic Origin? (Spuban, Mexican, Puerto Specify:		14. Race - A	white, etc. White
72 hours	15. Decedent's Edu	cation	16a. Decedent's Usual Occ	upation	10	6b. Kind of Busine	ess/Industry
New Park	(Specify only highest grade Elamentary/Secondary (0-12)	Collega (1-4or 5+)	(Give kind of work don life. DO NOT use reti	red)	uig		
12 ment	Elamentary/Secondary (0-12)		Homemaker			wn Home	
Due in the land	17. Father's Name (First, Middle, Last)				e (First, Middle, Mi		
yla Men Men Men Men Men Men Men Men Men Men				-	e Muench		
Maryla	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maiting Addrass (Stre	et and Number or Rur	al Route Numbar,	City or Town, Sta	ta, Zip Code)
der trans	Eileen M. Aker/ Da		19005 Rivert	on Street,		MD 20832 0c. Location - City	
altimore, mil. Pages 1 a partment of Hea portant. If Hem. y Injury or othe	20a. Mathod of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ R	emoval from State	metery, crematory or other p				
time Pa	4 Donation 5 Other (Specify)		ropolitan Cre		/24/00 A	lexandri	a, VA
Ball Permit Departiment important	21. Signature of Funeral Service Licenses	tuver.	500 Unive	. Collins	W. Si	lver Spr	c. ing, MD 20901
Physician	23a. Part1. Enter the disease or compli- shock, or heart failure. List only or	ications that caused the death. ne cause on each line.	Do not antar the mode of d	ying, such as cardiac	or respiratory arres	st,	Approximata Interval Between Onset end Deeth
/Medical Examiner	Immediate Cause (Final disease or condition rasulting In death)	Pneumonia					1 month
No. of Street, or other Persons and Person		Dua to (or	as a consequence of):				
D #		Dehydration					1 month
(ecords, P.O. Box 68760, law requires that the death certificate be executed as been signed by the attending physician and s 2 should be detached for use as the burial-transit	Causa (Diseasa or Injury that initiated events resulting in death) Last		as a consequence of):				
P.O. BOX		f.	ting in the underlying cause	given in Pert I.	23b. Did tob	pacco uae contrit	bute to the causa of death?
igned by the state of the detached is the detached in the detached in the state of					1 □ Ye	8 <u>3</u> € No 3[Probably 4 Unknown
Vitai Records, sician: The law requires to certificate has been signs irector, page 2 should be on the control of the control	SIADH				24e. Was an perform		4b. Wara autopsy findings eveileble prior to completion of ceuse of death?
The law					1 ☐ Yes	2 (XNo	1 □ Yas 2X No
Vitai	25. Was case referred to medical			26. Place of Deal	h (Check only one)	
	1 Yea 2F No	fospital: 1 inpatient 2 in	ER/Outpatient 3□ DOA	Other: 4 Nursing Ho	ome 5 Residen	nce 6 Other (Specify)
Attanding Physic death. •ctor: After this by the funeral d		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1	jury at /ork? □ Yes 2 □ No	28d. Describe how	w injury occurred	
Division c tail or Attanding P as after death. The Director: After t ad in by the funera	3 Suicide 6 Could not be determined	28e. Place of tnjury - At hor building, etc. (Specify)	ma, farm, street, factory, offic	8	28f. Location (Street, City or Town,		or Rural Routa Number,
Div To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my knowner: On the basis of examination and manner stated.					
ro the comple	29b. Signature and title of certifier		29c. Lice	nse number	29	d Date signed (A	fonth, Day, Year)
1318	1 6. The	acy M.D	. D 4	3430		T., 1., 2/	2000
	30. Name and address of person who co	emplated cause of death (Item		J430		July 24	2000
		1 Olandwood C		y, MD 208	32		
State	24 Date filed (Marth Day Veer)	32. Registrar's Signet		/			
Registra	1111 O F 000	1) Speva	D. spark	2			



State of Maryland / Department of Health and Mental Hygiene 00 24958

				Cei	rtificate of	f Death		Reg. No.		-1500
0 1	1. Decedent's Name (First, Middle	2. Dete of Month		Yeer	3. Time of Death					
Physician /Medical	Louis F	R. Del	apotaire				July		2000	9:25 PM
Examiner	4e Fecility Neme (If not Institution	, give street end nu	amber)			4b. City, Tow	n, or Location of D	eeth 4c. Cou	nty of Deeti	h
	Montgomery Ger	neral Hos	pital			Olne		Me	ontgo	nery
Funeral	5. Social Security Number	6. Sex 1⊠ M 2□ F	7. Age (In yrs. le		If Under 1 Yes Months Dey			Birth Day, Year)	9. Birti	hplece (State or Foreign untry)
Director	578-30-3470	IZON ZUF	73	Yrs.			Feb.	Pay. Year) 10, 1927	Wash	nington, DC
ms 23a or 28a-1 show I must be notified at	Usual Residence of Decedent 10a, Stete 10b, County		10c. City.	Town or Lo	ocation				}	t0d. Inside City Limits
show	Maryland Montg	000000			pring					1 ☐ Yes 2 ☑ No
or 28a-1 st be notified Director	10e. Street end Number	omery	311	vel 5	10f. Zip Code			10g. Citizen	of What Co.	untry?
0 8 0		Denders								
r items 23a anner must Funeral	10909 Bucknell		cedent Ever in U,S	13	209 Wes Decedent of		in? (Specify Yes o	USA 14. F	Race - Amer	ricen Indien,
Fun	1 Never Married 2⊠ Marri	Armed F	orces? 2 □ No		If Yes, specify Cu	ban, Mexican,	in? (Specify Yes o Puerto Ricen, etc.		Bleck, White	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	TT TATLAT BY	1	1□Yes 2☑N	o Specify:		Spe	city: Wh	ite
	15. Decedent	's Education		16a. Dece	dent's Usuel Occ	upetion		16b. Kind o	Business/I	Industry
nt, the Medical Ex. Completed b	(Specify only highes Elementery/Secondery (0-12)		(1-4or 5+)	(Give	kind of work don DO NOT use reti	e dunng most (red)	of working			
E O	12	Conego	(1-40101)		Remode1	er		Home	e Impi	covement
BeC	t7. Fether's Name (First, Middle,	Last)				18. Mother	's Name (First, Mic	ddle, Maiden Sun	neme)	
To	Louis Delapotai	re, Sr.				Irma	McIndoo			
	19e. Informent's Name/Reletions	nip (Type, Print)		19b. Meili	ng Address (Stre	et end Number	or Rurel Route No	amber, City or To	wn, State, Z	(ip Code)
other traumatic	Nell Delapotair	e / Wife		1090	9 Buckne	11 Driv	re, Silve	er Spring	g, Mar	yland 20902
	20e. Method of Disposition		20b. Pla	netery, cre	osition (Neme of metary or other p	lece)	Dete	20c. Locatio	on - City or	Town, State
5	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S)		1 21616				07/26/0	0 Silver	Spri	ng, Marylan
injury Se.	21. Signature of Funerel Service	icensee		2:	2. Name end Add	lress of Fecility	Hines-R	inaldi F	unera	1 Home
once.	De Glan	Dem	Olen	1	1800 Net	w Hamps	hire Ave Maryland	nue 20904		
	23a. Part1. Enter the disease, fr shock, or heert failure. Lish	complications that	ceused the death.							Approximete Intervel Between
g physicien end es the bunal-transit edical Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest	б	Due to (or e	es e conse	quence of):		.4		1	2 sax syears
Se Se		d								
detached for u	Pert II. Other significant condition	ns contributing to d	deeth but not result	ting in the u	inderlying ceuse	given in Pert I.	23b.	Did tobacco usa	contributa	to the cause of death?
Phy Y								1 Yas 2 N	0 3 P	robably 4 dinknown
b b										
should leted								Wes en eutopsy performed?	1	Were eutopsy findings eveilable prior to completion of ceuse
pe 2 shoul										of deeth?
g 0								1□ Yes 2□N	0	1□Yes 2□No
rector, pag	25. Was cese referred to medical exeminer?						of Deeth (Check o	nly one)		
P P	1 ☐ Yes 2 ☐ No			R/Outpatie	N 3LI DOA		sing Home 5 🗆 I			cify)
pletely filled in by the funeral edical Certification:	27. Menner of Deeth 1 Naturel 5 Pendin 2 Accident investig	ation	of Injury nth, Dey Year)	28b. Time o Injury	V	juryet vork? □Yes 2□N		ribe how injury or	curred	
d in by the	3 Suicide 6 Could I 4 Homicide determ	100d 200. FIELD	e of Injury - At hon ding, etc. (Specify)	ne, farm, st	reet, fectory, offic	00		on (Street end Nor Town, Stete)	imber or Ri	urel Route Number,
lical C	29a. Certifier 1 Certifyin (Check only one)	g Phyelclan: To the Examiner: On the b	e best of my know basis of examinetic nner steted.	ledge, deet on end/or in	h occurred et the	time, date end y opinion, deet	plece, end due to	the ceuse(s) and ime, date end ple	l menner as ce, end due	s steled. e to the ceuse(s)
To the Funeral Dir completely filled in Medical Cert	29b. Signeture end title of certifier					nse number				h, Day, Year)
- 0					2	3190	8	7.1.	27 7	ורשוני
1	20 Nome and editions of access	who completed and	en of docth (Ita-	22a) /Tues	Print)	-	-	July,	147	2000
	30. Name and address of person warner D. FER	Res w. D.	3305 ND	RTH LE	TSURE IN1	aca Au	ULENTED	SILVER S	PRING	MARYLAND
State	31. Dete filed (Month, Dev. Year)	32.	Registrer's Signetu	IFA			-			10.00
Registrar	31. Dete filed (Month, Dey, Year) JUL 2 5	2000 1	seneva	19.	Sport	2				
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State of Maryland / Department of Health and Mental Hygiene 00 24959

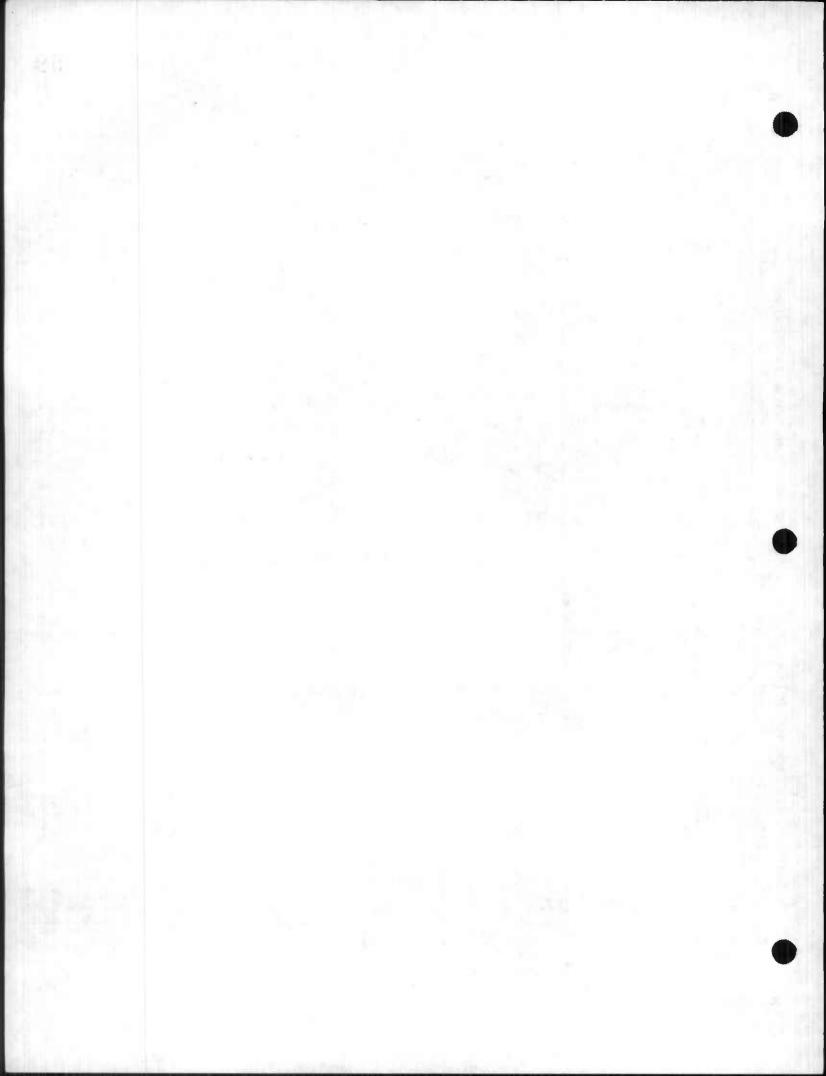
				(ertificate o	t Death	Re	g. No.	Non-	707	
	Physician /Medical	Decedent's Name (First, Middle, LU		EMAR			2. Data of Death Month JULY 1	Day 20	Year	rime of Death .:53 AM	
	Examiner	4a Facility Name (If not institution, SHADY GROV		T HOSP	ITAL	4b. City, Town, or Le ROCKVII	LE		GOMERY	7	
	Funeral Director	218-34-5101	5. Sex 7. Aga 1 M 2 F 7. Aga	(In yrs. lest birthd	Months Day		8. Date of Birth Month, Dey, June 1	^{Year)} 193:	9. Birthplace (Country) 3 Mar	State or Foreign	
	death with the Maryland ms 23e or 28e-f show crass be neutred at neral Director	Usual Residence of Decedent	gomery	10c. City, Town o	r Location					side City Limits	
	3a or 28a-f s libe month.	10e. Street and Number 18953 Abbot	tsford Cir	cle	10f. Zip Code	20876	10	g. Citizen of W	hat Country?		
020	urs after Learning by Fur	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? d 1 Yes 2 No If Yes, Give Yaar or Datas:		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puarto	ecify Yas or No- Rican, etc.)	14. Race	- Amarican Inc k, White, etc.		
21215-0020	within 72 ene. then "net he Work	15. Decedent's (Specify only highast Elementary/Secondary (0-12)	Education grade completed) Coltege (1-4or 5+) (C	ecedent's Usual Oci Bive kind of work do fe. DO NOT use ref Medical	na during most of work ired)	16b. Kind of Business/Indus U.S. Gover				
Maryland	Antai Hyginked other	17. Fathar's Nama (First, Middla, La Matthew Dorse	ist)			18. Mother's Nam	anor Ha	wkins			
	and 2 should be seen and N	19a. Informant's Name/Relationship (Type, Print) Thomas N. DeMar (Husbaid) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town 18953 Abbottsford Cir., Germa								20876 MD	
Baltimore,	Pages 1 nent of He my or oth	20a. Method of Disposition 1 Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of camatery, cremetory or other place) 20c. Location - City or Town, State 20c. Location									
Balt	Departing Departing Importures any Inji any Inji ang Inji	21. Signature of Funeral Service Li	C. Mos	ndly							
ox 68760,	h certificate be executed and ing physician and ruse es the burial-transit and Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Cardi	Myoca ue to (or as a cor omyopa ue to (or as a cor	nsequance of): thy nsequence of):	nfarction			1 h	our ears	
P.O. B	thet the death of by the ettern detached for un	Part II. Other significant conditions Pulmonary		not rasulting in th	ne underlying cause	given in Part I.	23b. Did tot			cause of death?	
Division of VItal Records,	The lew requires that sale has been signed by page 2 should be determined.	Pulmonary	Embolism				24a. Was an perform		available	utopsy findings e prior to lion of ceuse 17	
tal R	certificate has rector, page 2	25. Was case referred to medical				26 Place of Deel	1 ☐ Ye	0.000	1 🗆 Yes	2 □ No	
>	certific irector,	examiner? 1 Yes 2 No	Hospitat:	- PR-010		Other:					
ion of	Attending Physicien: ordeath. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 XNaturat 5 Pending 2 Accident investigat	1 ☐ Inpatien 28a. Date of Injury (Month, Day)		ne of 28c. In	njury at Nork?	ome 5 ☐ Resider 28d. Describe ho				
Divis	To the Hospital or Attending within 24 hours after death To the Funeral Director. A completely filled in by the f Medical Certificat	27. Manner of Death 1 2XNaturat 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Describe how injury occ Injury 28b. Describe how injury occ North City or Town, Steete)							er or Rural Rou	te Number,	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
0	S South	29b. Signature and title of certifier	rquiat	MD		25881		1.0	(Month, Dey,	_	
		30. Name and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person who does not be seen and address of person and address of person and address of person and address of person addre	no combilated cause of deal	med (C	rpe, Print) Cente	assel or Drive	Rock	rollic	nd ac	750	
	State	31. Date filed (Month, Dey, Year)	32. Registrar	's Signature	1 1						

DHMH 16 Rev 6/95

State

Registrar

JUL 2 3 2000



State Registrar 31. Date filed (Month, Day, Year)

2401 Research BLVD Suite 340 DY A MENDHIBATTA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

Rockinllo

MDLOSS

DHMH 16 Rev 6/95

and the Williams N. J. W. H. S. H. H. W. H. and the state of t mallet And and Y

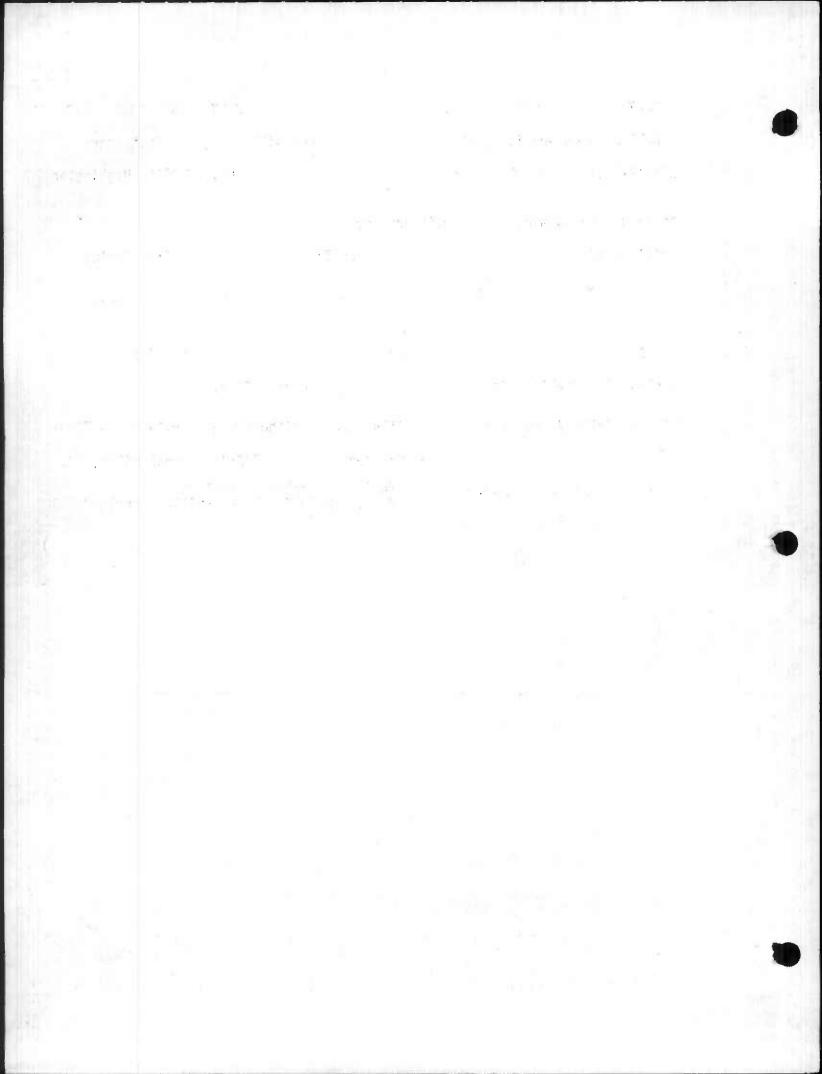
	000, Montg.Co.	00	ertificate of	Death	2. Dete of De	Reg. No.	4130
Decedent's Neme (First, Middle					Month	Dey Y	3. Time of Dea
Madelyn Edna. 4a Facility Name (If not institution	Dickerson			4b. City, Town, or L	JULY ocation of Deeth	22, 200 4c. County of	
	MILL DR.			CAPITOL	HEIGHTS		ICE GEORGES
5. Social Security Number	6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birl (Month, Da		. Birthplace (State or For
577-07-9713	1□ M 2厘F 90	Yrs.	Months Days	Hours Min.		13,1909	W. VA.
Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Le	ocation				10d. Inside City Li
				n Tairna			1 ☑ Yes 2 ☐
MD. PRINC	E GEORGES		10f. Zip Code	EIGHTS		10g. Citizen of Who	21
				- l			
7606 WALK	ER MTIL DR. 12. Wes Decedent Ever in	U.S. 13.	Was Decedent of I	743 Hispanic Origin? (S)	pecify Yes or No		American Indien,
1 Never Merried 2 Merri	Armed Forces? ied 1 ☐ Yes 2 ☒ No		If Yes, specify Cub 1 ☐ Yes 2 ¼ No	en, Mexican, Puerto	Rican, etc.)	Black, Specify:	White, etc.
15. Decedent	t's Education	16a. Dece	edent's Usual Occup	pation		16b. Kind ot Busin	
(Specify only highes Elementery/Secondery (0-12)	completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	duning most of world)	king		
12	College (1401 34)		HOMEMA	KER		H	HOME
17. Fether's Neme (First, Middle, I	Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
	HEDRI	CK			NORA	HEDRI	CK
19e. Intormant's Name/Reletionsh	nip (Type, Print)	19b. Melti	ling Address (Street	end Number or Ru	rai Route Numb	er, City or Town, St.	ate, Zip Code)
	CKERSON/SON			ITEM #10)		T. 0
20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation			osition (Name of emetory or other pla		Date	20c. Location - Ci	ly or Town, State
4 Donation 5 Other (St			ERS CREMA		7/25/00	RIVERDA	ALE, MD.
21. Signature of Funeral Service I	Licensee	2	22. Name and Addre	ess of Facility			
11/11/16	ambered MO	00091 (CHAMBERS	FUNERAL H	IOMES.P.	A. RIVER	RDALE, MD. 2
! resulting in death)	a. CHRON Due to MALN	(or es e conse	equence ot):				MONT
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if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	URINA	224	TRA	LET 1	NFEC	TIGA	WEEK
thet initiated events		(or as e conse					
Part II. Other significant condition	ns contributing to death but not re	esulting in the u	underlying cause gi	ven in Part I.		0	
CHORAL	ons contributing to death but not re				10	0	
- C WICO LAIC	OBSRUCT				1 □	Yes 2840 3	24b. Were autopsy find available prior to
- C WICO LAIC					1 □	Yes 2 No 3	24b. Were autopsy find available prior to
- C WICO LAIC	OBSRUCT				1 □	an autopsy	Probably 4 Un 24b. Were autopsy find available prior to completion of caus of deeth?
DENEA 25. Was case reterred to medical	OBSRUCT				24a. Was perfo	an autopsy med?	Probably 4 Uni 24b. Were autopsy find available prior to completion of caus of deeth?
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			C	ertificate	of Death	1	Reg. N	ال. ال	24962		
Physician	1. Decedent's Name (First, Mic		1000			2. Dete Mont	of Deeth	ley Ye	3. Time of Death		
/Medicai	MAKT	ELLEN	DOVE			JUL	Y 25	200	0120 111		
Examiner	4e. Fecility Name (If not institut	od Nursing Co				own, or Location of	Deeth 4	C. County of I			
Funeral	5. Social Security Number	6. Sex 7.	Age (In yrs. lest birthd	ay) If Under 1		VIIIe	of Birth	1 0	Omery Birthplece (State or Fore		
Director	214-12-7451 Usual Residence of Decedent	1□M 2⊠F	88 Yrs	. Months	Jeys Hours	Mar	. 30 1	912 h	lashington,D		
w te	10e. State 10b. Cour	ity	10c. City, Town o	Location					10d. Inside City Llm		
r 28a-f show incittled at frector	Maryland Mor	itgomery	Gaithe	rsburg					1 2 Yes 2 □ !		
r Items 23e or 28e-fs iner must be notified Funeral Director	10e. Street end Number 2 Mills Road			10f. Zip C				itizen of Whe			
ns 23	11. Marital Status	12. Was Decede	nt Ever In U.S. 1)877 nt of Hispenic O	rinin? (Specify Yes		ited S	Tates American Indien,		
by by	3 ☐ Widowed 4 ☐ Divorce	Armed Force	s?	If Yes, specify		rigin? (Specify Yes n, Puerto Rican, et :	c.)	Bleck, White, etc. Specify: White			
"netural",	15. Deced	ent's Education nest grede completed)	16e. De	cedant's Usuel (Occupetion done durina mos	st of working	16b.	Kind of Busin	ass/Industry		
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	Charles R. H	lawkins, Sr.			Ann	a Story					
theelin and Marke other traumatic	19e. Informent's Name/Relatio	nship (Type, Print)	19b. M	eiling Address (S	Street end Numb	per or Rurel Route N	lumber, City	or Town, Sta	ita, Zip Code)		
item 27 other tu	Ellen B. Selby 20e. Method of Disposition	// Daughter	2 M 20b. Pleca of Di	ills Roa	d, Gai	thersburg					
Department of Important: If its any injury or of once.	1 2 Burial 2 Cremetion 4 Donetion 5 Other	(Specify)	cametery, o	Cemetery or other	er pieca) /	7/28/			or Town, State		
Important International	21. Signeture of Funeral Service	a Licensee Bar	her	Muriel		er Funera			yland 20882		
signed by the ettending physician and a poly be deteched for use as the bunel-transit and property and by Physician/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Causa (Disease or injury that initiated events resulting in death) Lest		Due to (or es e conducto (or e	sequenca of): diseas saquenca of):		ascular	dis	ease	years years		
d by the ettending leteched for use a Physician/M	Pert II. Other significant condit	d	but not resulting in the	e underlylng cau	se given in Part	I. 23b.		_/	buts to the cause of dec		
been signed should be de leted by F						24e.	Wes an euto	7	4b. Were eutopsy finding		
2 N D						-	performed?		eveileble prior to completion of cause of deeth?		
s certificate hadirector, page							1 ☐ Yes	2 No	1 □ Yes 2 No		
certificate irector, pag	25. Wes case refarred to medic examiner?	Hospitel:			Othon 1 /	e of Death (Check					
	27. Mennar of Deeth	1 ☐ Inpa 28a. Date of In (Month, D	jury 28b. Time		Injury et Work?	ursing Home 5 🗆 28d. Desc	Residence cribe how inju		Specify)		
To the Funeral Director. After the completaly filled in by the funeral Medical Certification:	3 Sulcide 6 Coule	d not be 28a. Pleca of I	njury - At home, ferm, etc. (Specify)	М	1 Yes 2	28f. Local	ion (Street e or Town, Stet	and Number o	or Rurel Route Number,		
To the Funeral Director: completaly filled in by the Medical Certifical	29a. Cartifier 1 Certify (Check only one)	ing Physician: To the bes if Examinar: On the basis end menner:	of axamination end/or	eth occurred at i	he time, deta er my opinion, das	nd place, and dua to	tha cause(stime, dete er	s) and manna nd place, end	ar as stated. due to the cause(s)		
· 2 2 4							1				
/	29b. Signeture and title of certification	L. Tomsk	Bo, md	29c. L	D5/9/ $\frac{1}{2}$	6	29d. De	ete signed (M	10nth, Day, Year) 26, 2000		
To the	29b. Signeture and title of certification of the patricia and eddress, of person patricia L. To	L. Tomsk	20, MD death (Item 23a) (Typ 11/40 ROC		D5191 Pike, j	16 PMB 348	Uc	ete signed (M 1 / 4 / 6 Kville,	ionth, Dey, Year) 26, 2000 MD 20853		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. JVW State of Maryland / Department of Health and Mental Hygiene 24963 00-3975-045 RICHARD DUNN Amend Item#28a perPHYG794 4/13/2001 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month JULY I8, 2000 09:35 A.M RICHARD ALBERT DUNN, III /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner PENINSULA REGIONAL SALISBURY WICOMICO If Under 24 Hrs. 5. Social Security Number 6. Sex XXM 2□ F If Under 1 Year 8. Date of Birth (Month, Dey, Year)
April 16,1982

8. Birthplaca (State or Foreign Country)
Washington, D.C. 7. Aga (In yrs. lest birthday) **Funeral** Months Days Hours Yrs. 217-04-7513 18 Director Usuel Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Worchester Berlin 28a-1 the Medical Examiner must be notifi-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or USA 10218 Old Ocean City Boulevard 21811 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 ☐ Yes Ž**O**No If Yes, Give Year or Detes: Never Married 2 Married Maryland 21215-0020 b 1 ☐ Yes 2 🗓 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) Waiter Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) nd Mental marked of 8 Richard Albert Dunn, Jr. Deborah Ann Reynolds 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) .85 Pages 1 and 2 of of Health : If Item 27 Deborah Ann Reynolds-Dunn (Mom) 10218 Old Ocean City Blvd., Berlin, Maryland 21811 Baltimore, 20b. Plece of Disposition (Neme of camatary, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 7-25 8 1 Buriel 2 □ Cremetion 3 □ Removal from Stete Cedar Hill Cemetery 2000 4 □ Donetion 5 □ Other (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Nema end Address of Fecility à Pearson Funeral Home 472 N. Washington St., Falls Church, VA 22046 malg 23a. Pert1. Egler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Intervel Between Onset end Death Physician tmmediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Box 68760. es the Due to (or es e consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the cause of death? Unknown 1 Yes 2 No 3 Probably þ Records, 90 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? page 2 should Certification: To Be Completed 2 No 1 Yes 2□ No of Vital after death.

Director: After this certifica 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 28a. Dete of Injury
(Nonth, Dey Year)

28b. Time of Injury
(Nonth, Dey Year)

28c. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 27. Menner of Deeth 28c. Injury et Work? Division 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident the 281. Location (Street Ind No. City or Town, State) 6 Could not be determined 3 Suicide filled in by 4 Homicide 05 ocdura within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier completely \$ 29d. Date signed (Month, Dey, Year) 29b. Signature and this of certifies 29c. License number O.C.M.E. JULY 20, 2000

State Registrar

31. Sete filed (Month, Day, Year) JUL **25** 2000

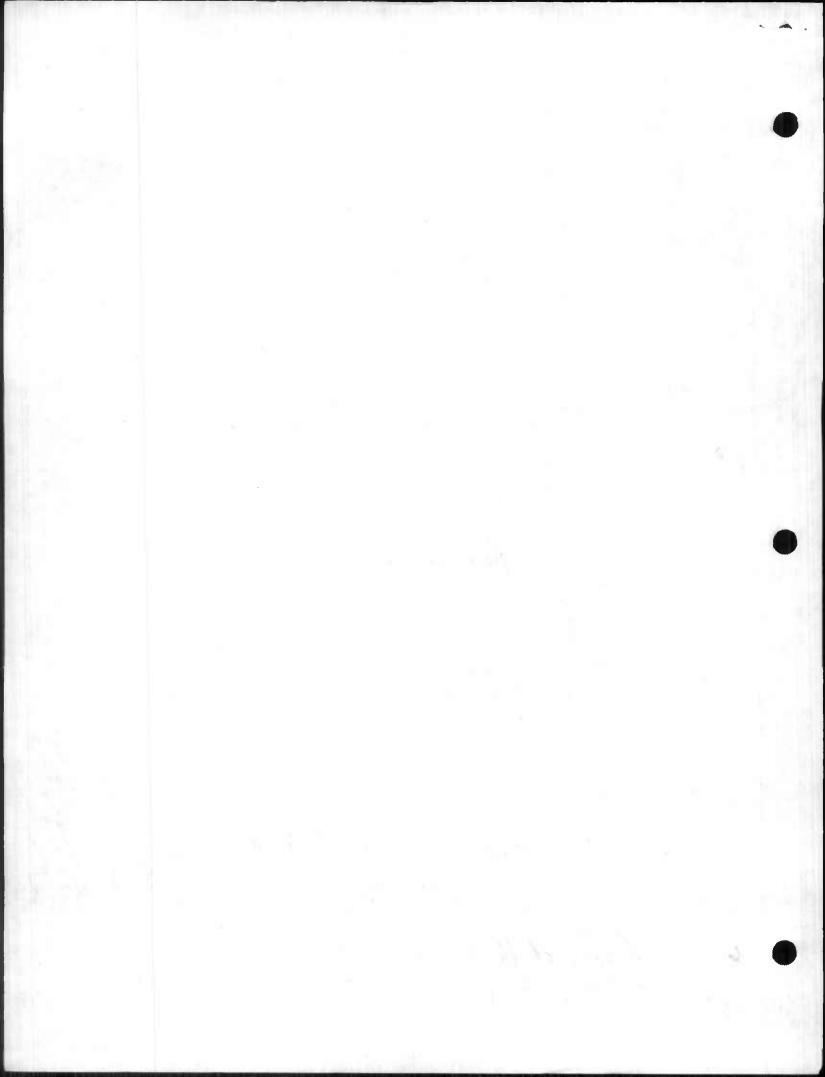
e and address of person who comp

UNDAF

32. FI strar's Signature

111 Penn Street, Baltimore, Maryland 21201

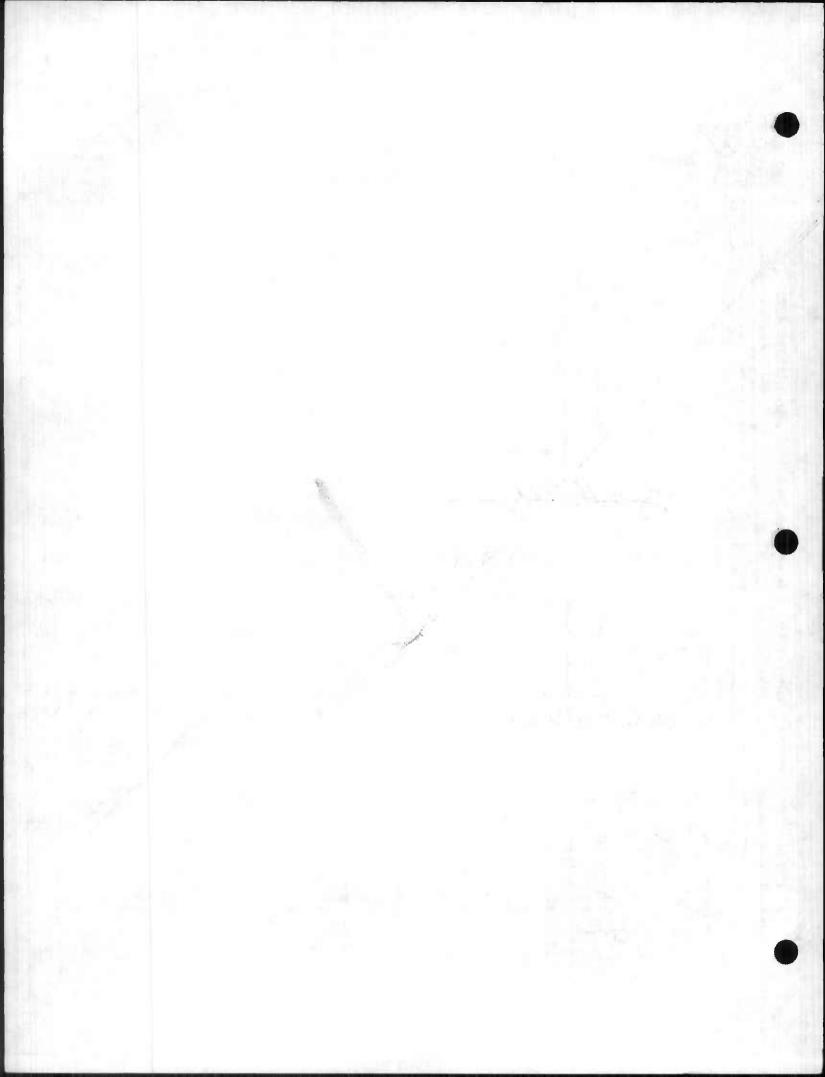
3a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

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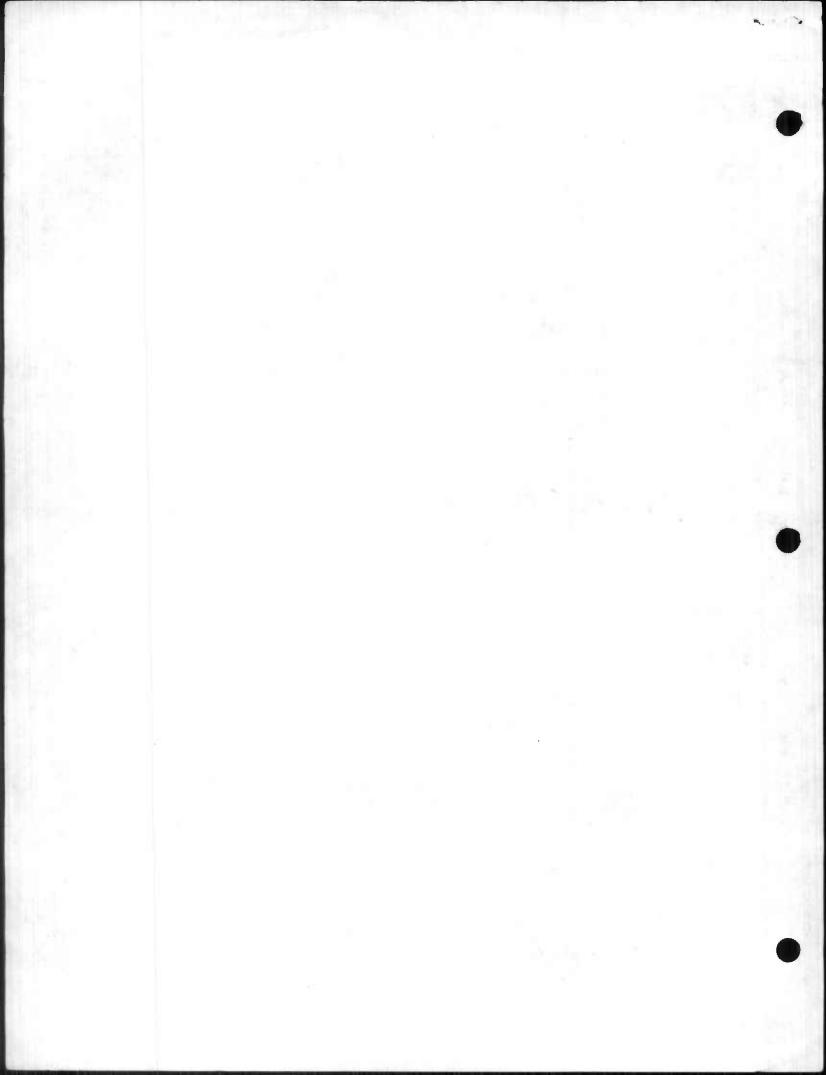
			Ce	nificate of	Death		Reg. No.	700			
Physician /Medical	Edward Alphonada Durbin dar, 24, 2000 0.03 p										
Examiner	4e Fecility Name (If not institution, g	ive street and number)	THE NEW		4b. City, Town,	or Location of Dear	th 4c. County	of Deeth			
	SHADY GROVE	ADVENTIST	HOSPITA		ROCKV:		MON	TGOMERY			
Funeral Director	5. Social Security Number 6. 579-05-1087	Sex 7. Age (In yrs. last birthday)	Months Dey		Hrs. 8. Dete of 8i	th 4, 1912	Birthplace (State or F Country) Onlo			
2	Usuel Residence of Decedent										
Marylar Had at fled at	Maryland Montgot		Rockvil					10d. Inside City I			
or 21a-f s be notified Director	10e. Street and Number	120 - 911 /	PLIN NA	10f. Zip Code	Y T		10g. Citizen of \	Whet Country?			
	690 College Par	kway			20850		United	d States			
urs after death vil.; or flems 23s Examiner must by Funeral	11. Meritei Stetus 1 Never Merried 2 Married	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No	er in U,S. 13.	Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.		(Specify Yes or Nuerto Rican, etc.)	0- 14. Rad Blad Specify	ce - American Indien, ck, White, etc. y: White			
	3 □ Widowed 4 □ Divorced	Yeer or Detes:	1 40 5		The state of		405 151-1-11	A - 1			
led within 72 ho tygiene. we than "natural, it, the Medical. Completed	15. Decedent's (Specify only highest g Elementery/Secondery (0-12)	ducation rade completed) College (1-4or 5+)	(Give	dent's Usuel Occi kind of work don DO NOT use retir Carp	e durina most of	working	16b. Kind of Business/Industry Construction				
vid be fled Mental Hyg rksd other file event, I	17. Fether's Neme (First, Middle, Las Leo Severnus	urbin	T. P. C.		18. Mother's Franc	Name (First, Middle es Parke					
and 2 sho allth and 1 27 is ma ar treums	19a. Informent's Neme/Relationship John Durbin/					r Aural Route Numb y, Rockvi					
Pages 1.	20e. Method of Disposition 1 🖾 Burlel 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec		20b. Plece of Disponentery, cre Gate of	matory or other pi	lace)	July 27 2000		- City or Town, State ville, Maryla			
Departs Departs imports any inja	21. Signature of Funeral Service Lic	onsee Oull	2.	Name end Add Rapp Fun 933 Gist	ress of Fecility eral and Ave., S	d Cremati Silver Sp	on Servi ring, Ma	ces cryland 2091			
	23e. Partt. Enter the disease, or co shock, or heart feilure. List on	nplications that caused th						Approximate Interval Betwe			
Medical Examiner particular property with the property of the	Immediate Cause (Finel disease or condition resulting in deeth)	. Aspire	ation Due to (or es a conse t fail	YRUMO quence ot): UR	nia			1 Wee			
certificate be assouted ding physician end ise es the bunal-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): C. Due to (or es e consequenca of):										
death of attended for us											
	Pert II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause of	given in Pert I.			ontributa to the causs of o			
that the ed by th detech	Atrial tibril	lation				10	Yes 2 No	3 Probably 4 Un			
been shoul							s en eutopsy formed?	24b. Were eutopsy find available prior to completion of cau of deeth?			
The law rate has to pege 2 s						1	Yes 28No	1 □ Yes 2 □ N			
certificate rector, peg	25. Wes case referred to medical				OO Place of			1 Tes 2LAN			
Physician: this certific ral director. To Be	examiner?	Hospitel: 1 Dinpatient	2□ ED/Outratia	- 20 DOA C	ther:	Deeth (Check only					
ding Physic h. After this co funeral dire tion: To	27. Menner of Death 1 Poleturel 5 Pending	28e. Dete of Injury (Month, Day)	2 ER/Outpetie 28b. Time of Injury	28c. Inj	ury et ork?	28d. Describe	how injury occur				
tal or Attending P rs after death. at Director: After t led in by the funera Certification:	2 Accident investigeti 3 Suicide 6 Could not 4 Homicide determine	9	28f. Location City or To	(Street and Numi own, Stete)	ber or Rurel Route Numbe						
Hospi 4 hou Funer loly fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end mann control of the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and menner steled.										
within 2 To the comple	29b. Signature and Mre of cartifier			29c. Lice	nse number		29d. Date signe	ed (Month, Dey, Year)			
3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -	1 Data	M	0	24	971		T. L.	75 7000			
3	30. Name and address of person who	completed cause of dee		() 11	md	Dennis	Friedman	25, 2000			
	31. Dete tiled (Month, Day, Year)	32. Registrer's	Signature	Kockülle	110	BEITTE	1 1 1 Cullar	,			
State Registrar	1111 2 8 2		Signature G.	Spark	2						



State of Maryland / Department of Health and Mental Hygiene 11 21 955 Carlos DeAlmeida

am	nend item 23	a,27,28a,b,c,d,e,f,per 1. Decedent's Nema (First, Middla, La		0 yf C	ertifica	e of	Death	, 2	Data of Dea				a of Death
	Physician	Carlos Alberto T	oledo De Alm	eida					Month July	24	Yaar 2000	11:	22 P.M
	/Medical Examiner	4a Facility Nama (If not institution, give	va street and number)				4b. City, To	wn, or Loca	tion of Death	4c. County	of Death		
K,	Examinei	Peninsula Regiona	d. Medical Çer	nter			Salis	sbury		Wic	omico		
	Funeral Director		Sex 7. Aga (In)	rs. last birtho		1 Yaar Days	If Undar Hours	24 Hrs. 8 Min.	Data of Birth (Month, Day OCT	1963	9. Birthpl Braz	aca (Ste	ata or Foraign
	2 .	Usual Rasidance of Decedent 10a, Stata 10b, County	10-	City, Town o	- Ation							04 15 -14	le City Limits
	e Maryla la-f shor iffiad at ctor	MD Montgo			Sprin	9						10	Yas 2 No
	ier death with the Marys Herns 23e or 28e-1 sho Iner must be notified at Furneral Director	10e. Street and Number 13836 Tobiona Dr				906				10g. Citizen of 1 Brazil	What Coun	try?	
020	Exam Exam by F	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in Armed Forcas? 1 Yas 2 No if Yes, Giva Yaar or Datas:	n U,S.	13. Was Dece If Yas, spe 1 Tas		lispanic Ori an, Mexican Specify:	igin? (Specif n, Puarto Rid	y Yas or No- ≎an, atc.)	14. Rad Bla	e - Amarica ck, Whita, a ite		n,
21215-0020	enn 72 ho en "natur Medical spleted	15. Decedant's E (Specify only highast gra Elementary/Secondary (0-12)	ducation ada complated) College (1-4or 5+)		ecedant's Usu iiva kind of wo a. DO NOT u		eation during mos d)	t of working		16b. Kind of B	usinass/Ind	ustry	
	be filed within 72 ho isi Hygiene. 5 other than "natur event, the Madical. Be Completed	17. Fathar's Nama (First, Middla, Last)	Ne	ver Wo	rkea				Maiden Sumer	ne)		
yla	Ment Ment affic e	Amuri Santos De	Almeida				Idal	linda	Toled	10			
, Maryland	Health and Shi	19a. Informant's Name/Relationship (Paulo De Almeida	• • • • • • • • • • • • • • • • • • • •							r, City or Town, ring, M			
itimore,	Pages 1. ment of He ant: If Hen ury or oth	20a. Method of Disposition 1 Burial 2 Cramation 3 C 4 Donation 5 Other (Special	Ramoval from Stata	cematary.	isposition (Na cramatory or beake C	rema	tory	2	Date 28	Beltsv	ille,		a
Balt	Departition Depart	21. Signatura of Funaral Service Lice	nsea De DA		22. Name a Rapp 933	rd Addra Fun Gist	eral eral	& Cre	mation ilver	Service Spring,	es MD		
9		23a. Part Entar tha disaasa, or con shock, or heart failure. List only	plications that causad tha cona causa on each line.	laath. Do not	antar tha mo	da of dyir	ng, such as	cardiac or r	aspiratory ar	rast,		Approxi	imate Batween
	Physician /Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in daeth)	a	DROW	NING						1	Onsat a	and Daath
	executed in and ial-transit	Sequentially list conditions,	bDua t	o (or as a cor	sequance of)	:							
68/60,	ficate be physicia is the bur	Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): C. Dua to (or as a consequence of):									1		
. Box	v requires that the death certi been signed by the ettending should be deteched for use a leted by Physician/M	Pert il. Other significant conditions of	d	rasulting in th	na undarivino	causa on	van in Part I	1.	23b. Did t	obacco use co	ntribute to	the car	use of death?
F.O.	that the ned by the deteche									/es 2□ No	3 ☐ Prot		4 Unknown
Records,	The law requires the state has been signed, page 2 should be Completed by	E STUR			K.			4		an autopsy med?	ava	aileble p	psy findings rior to of causa
H	The law								100	as 2□No	1,0	Yes	2 No
ē		25. Was casa rafarrad to medical					26. Plece	e of Deeth (Check only o	na)			
>	Physical this center direction of the center	axaminar? N☐ Yas 2☐ No	Hospital: 1 Inpatiant	2 X ER/Outp	atient 3 D	OA Ott	ar: 4□ Nu			lence 6 🗆 Otl			
Division of Vital		27. Mannar of Death 1 ☐ Netural 5 ☐ Panding 2 ☑ Accidant Invastigation	,	28b. Tim Inju 10:	oo P	28c. Injui Woi 1 🗆	yat rk? Yas 2x0		d. Dascribe h ne water	ow injury occu	redsubje	ect e	entered
DIVIS	ne Hospital or Attending P n 24 hours affer deeth. The Funeral Director: Affer t pletely filled in by the funer edical Certification:	3 Suicida 6 Could not be determined	28e. Pleca of Injury - / building, etc. (Sp River	At homa, farm ecify)	, straat, factor	y, office		28	f. Location (5 City or Tox	Street and Num m, Stete) D	ber or Aura eal Is		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the Medical Certi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the ceuse(s) and menner end of an analysis of axamination and/or invastigation, in my opinion, deeth occurred at the time, dete and piece, and due and mannar stated.										ise(s)	
	within To the comp	29b. Signature and title of certifier	V.				a number			29d. Date signe			ar)
	2	Theoder 4.	fight wo	~		1:B.c	i.₩.E.		J	July 25	2000)	
		30. Nama and addrass of person who	complated cause of death (319 76	eeP, 4	1391 in	ore, M	laryland	1 2120)1	
	State Registrar	31. Data filad (Month, Day, Year) JUL 2 8 20	32. Ragistrar's S	ignatura 4	do	ed's	*						

JUL 2 8 2000



ate of Maryland / Department of Health and N Certificate of Death	Mental Hygiene	,00	24966	
	2. Date of Death		3. Time of Death	٦

Physici /Medi Exami

1. Decedent's Name (First, Middle, Last)

Funeral Director

permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiens. "Important if hem 27 is marked other than "natural", or flams 23s or 28s-f show important if hem 27 is marked other than "halfied! Examiner must be notified at 905s.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

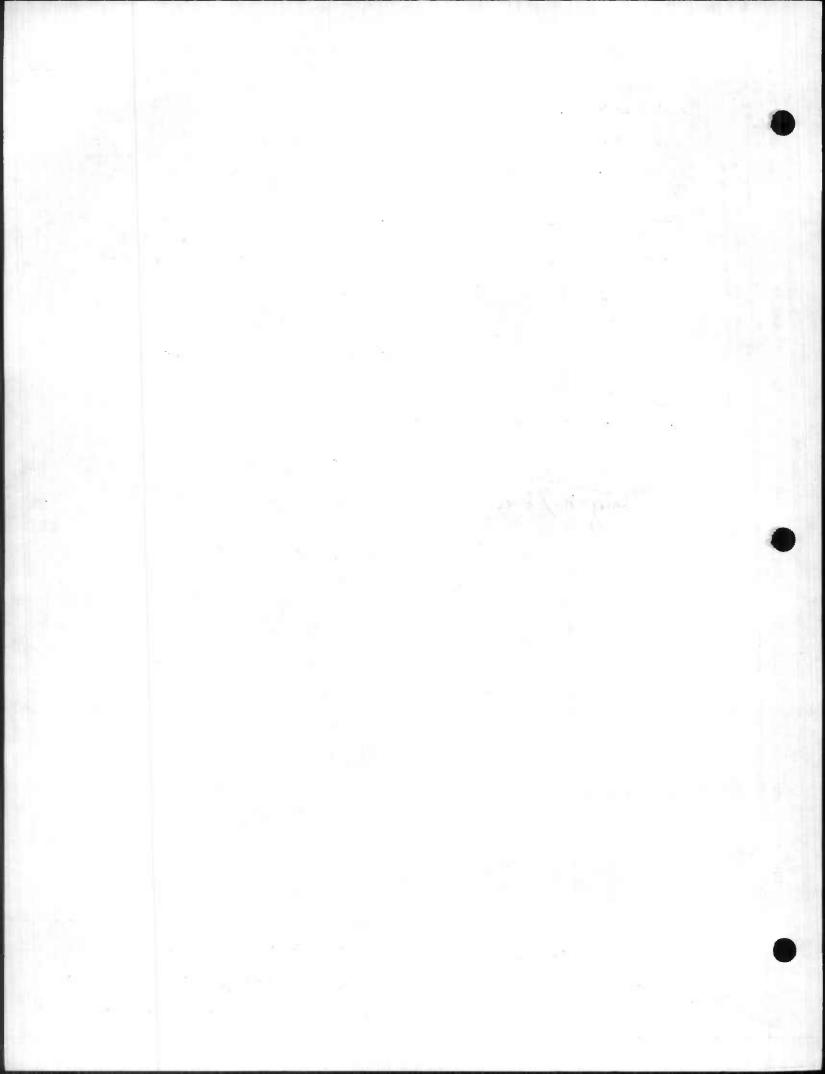
Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

al Ma	rtha El	zenni de	Guia						July 2	23, 200	00	6:25	PM
	acility Name (#	not institution, give	street end numbe	7		- 4	b. City, Tov	vn, or Loc	ation of Death	4c. County	of Death		
Sh	nady Gr	ove Adver	ntist Nur	sing Cen	ter		Ro	ckvil	11e	Mo	ntgo	nery	
57	clal Security No. 7-40-19 Il Residence of	74	ex □ M 202 F	ge (In yrs. last bi	rthday) If Unde Montha	Deys	If Under 2 Hours	Min.	8. Date of Birt (Month, Da May 5,	1909	9. Birthp Coun Ohio	lace (State or Fi try)	oreign
	State	10b. County		10c. City, Tow	n or Location						1	0d. Inside City I	Limits
Mar	ryland	Montgome	~~~	Caith	ersburg							1X Yes 2	□No
*	Street and Nurr		r y	Galen		p Code				10g. Citizen of V	What Coun	itry?	
10	1 Odend	hal Aven	#1018		20:	877				United	Stat	96	
11. M	farital Status	mai Aven	12. Was Deceder	t Ever in U,S.	13. Was Dece	dent of H	ispanic Ong	in? (Spec	ify Yes or No	14. Rac	e - Americ	an Indian,	
3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates				No	1 ☐ Yes	The said	Specify:	Pueno A	iican, etc.)	Specify: White			
Ele		15. Decedent's Ed		16a	. Decedent's Usu (Give kind of wo	al Occup	etion	of working	a	16b. Kind of Br			
Ele	ementary/Secon		College (1-4o	5+)	life. DO NOT	ise retired	1)	Or WOTKING					
3	8				Homemak	er				Own He			
17. Fa	ather's Name (i	First, Middle, Last)					18. Mothe	's Neme ((First, Middle,	Maiden Sumen	16)		
	ias Elz								Mitche				
		me/Ralationship (1			. Mailing Addres								
	ria Bro		ghter)		.3729 War		rden I	rive	-				
	Method of Dispo		Removal from Stet	comoto	f Disposition (Na ry, crematory or		ce)	- 1	Dete	20c. Location -	City or To	wn, State	
		5 ☐ Other (Specif)			of Heave	en Ce	meter	y 17/	/26/00	Silver	Sprin	ng, Mary	y1an
21. S	lignature of/Fur	nerel Service Licen	500	. 194	22. Name a	nd Addre	ss of Facility	1	DeVo	l Funera	al Ho	me	
)	70	with.	the.		10 E.	Deer	Park	Driv		thersbu			77
23a.	Pert 1: Enter th	a disease, or comp	olications that cause one cause on each	d the death. Do								Approximate Intarval Between	
	SHOCK, OF HEAT	List Only	ONE CEUSE ON BUCH	mid.						0	1	Onset and Dea	ath
	ediate Cause (F		(ano	n 11.	10	Mo.	× ~4	- Fra	,0,18	2	DAY	C
resuit	ting in death)	1-40	8.	Dua to (or as a	consequence of)		THE	NOI	100			W///	3
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that is	nitiated events ting in death) L		С	Due to or es e	consequence of):	27.4	241				1	11	
1000	ting in down y L												
			d								1		
Part II	I. Other signific	cant conditions co	ontributing to death	but not resulting i	n the underlying	cause giv	en in Part I.		23b. Did 1	obacco use co	ntribute to	the cause of d	death?
									10	fes 2□ No	3 Proi	bably 4∭Un	known
25. W										an autopsy med?	av	era autopsy find allable prior to mpletion of caus deeth?	
									101	es 2 No	10	Yas 2 No	,
25. W	Vas case raferre	ed to medical				1		of Death	(Check only o	na)			
1	☐ Yes 2☐X	10	Hospital: 1 ☐ Inpai				4 LAI INUI	sing Hom	e 5 Rasio	lence 8 Oth	ar (Specif	y)(y)	
27. M 1	lanner of Death Matural Accident	5 Pending Investigation	28a. Date of In (Month, D	ury ey Year) 28b.	Time of Injury M	28c. Injur Wor 1 🗆	yat k? Yes 2∐h		8d. Describe I	ow Injury occur	red		
3 4	3 Suicide 6 Could not be determined		28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)			y, office		26	8f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)			
	Certifier (Check only ane)	1 Certifying Phy □ Medical Exam	rsician: To the bes iner: On the basis and manner s	of examination en	e, death occurred d/or invastigation	at the tin	ne, date and pinion, deat	l place, ar	nd due to the d d at the time,	cause(s) and ma date and place,	anner as si and dua to	lated. the cause(s)	
29b. S	Signature and t	itle of ceruma)		29	c. Licens	e number			29d. Date signe	d (Month,	Dey, Year)	
		H/36	(D)			17	579	2		July 24	, 200	0	
			ompleted causa of			ve,	#504	Rock		Maryla		20852	
	ate filed (Month			rar's Signature	, ,								
31.0		UL 2 4 20	for a	eva /	9. pp	als	Ji Carallana						

State

Registrar



State of Maryland / Department of Health and Mental Hygiene 24967 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Physician July 27, 2000 10:30 a.m. Leslie M. Dulin, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Chestertown Kent Magnolia Hall Nursing Center If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days ₩XM 2 F Months 214-28-8035 Director 80 January 17, 1920 We Mills, MD **Usual Residence of Deceden** 10a, State 10b. County 10c. City, Town or Location worle 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla. Department of Health and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show you'rivry or other traumatic avant, the Medical Example must be notified anona. fXXYes 2 No Director Maryland Kent Galena 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 21635 USA 107 W. Cross Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: White 1 Yes 20No Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Gas & Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å John P. Dulin, Jr. Alma Beatrice Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) L. Mildred Dulin 107 W. Cross Street, Galena, Maryland 21635 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 3 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2000 Chestertown, Maryland Chester Cemetery 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 tellows Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or near feiture. List only one cause on each line. **Physician** /Medical Right Cerebrovos and an Immediate Cause (Final 18 mm 165 disease or condition resulting in death) Examine hell arono vos ala Acci del physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) vere vosculor Box 68760. Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. TELYes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed whore one completion of cause of deeth? Toches Vernenel 20 No Corcinona 1 ☐ Yes 2 ☐ No Attanding Physician: 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1□ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending al or Attanding attar deeth. I Diractor: Atta d in by the fun 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours after To the Funeral Discompletaly filled in Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature wild title of certified 29c. License number 29d. Date signed (Month, Day, Year) D17036 00 ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestatown Md 21620

DHMH 16 Rev 6/95

State Registrar

5 as on

31. Date filed (Month, Day, Year)
JUL 2 8 2000

5/6 Washington H

Ross, m.D.

JUL 2 8 2000 Journal 10 100 100

State of Maryland / Department of Health and Mental Hygiene 00 24958

				Cei	rtificate	of De	eath			Reg. No.		C4200	
	1. Decedent's Neme (First, Middle,	Last)							2. Dete of De	eth		3. Time of Death	
Physician	MARY	GOOTE	E	DEAN					Month July	25	2000	0435	
/Medical Examiner	4- F199-11					4b. 0	City, Tow	n, or Lo	cation of Deeth		ounty of Death		
Examiner	Contraction of the contraction o	Mill St.					Camb	ride	96		orches		
			7. Age (In yrs.	lest hirthriev)	If Under 1 \	1	Under 2	-					
Funeral		1□M 215F	89	Yrs.			lours	Min.	(Month, Dey, Year)			plece (Stete or Foreign intry)	
Director	215–48–9294 Usuel Residence of Decedent		03						June 2	yland			
pu #	10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
Age of the party o	MD Dorch	nester		7	Cambaai	A						1€Yes 2□No	
or 28s-fs	10e. Street and Number	lester			Cambri					40 000			
	10e. Street and Number	CL			10f. Zip Co		4.640				n of Whet Cou	intry?	
45 M 15 M											S.A.		
for dooth	11. Meritel Stetus	Armed For		,S. 13. \	Was Decedent If Yes, specify	t of Hispe Cuban, N	nic Origi Jexican,	n? (Spe Puerto I	cify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White		
4 24 E		d 1 ☐ Yes If Yes, Giv			1 Yes 27		pecify:				ecify: r.zh:		
by English		Yeer or De			,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			3,	pecify: who	ite	
of 2 should be flaed within 72 hours after the and Mental Hygiene. The marked other than "setural", or if traumatic event, the Medical Examin To Be Completed by Fi	15. Decedent's (Specify only highest	Education		16e. Deced	dent's Usuel C kind of work of	ocupetion	n na most e	of workin	na	16b. Kind	of Business/la	ndustry	
un un 100	Elementery/Secondery (0-12)	College (1	-4or 5+)	life. I	DO NOT use /	retired)	· g						
worth a	11		2		teache:	r				pul	olic so	chools	
d other		ast)				18	. Mother	s Neme	(First, Middle,	Maiden Su	meme)		
fentito di contra di contr		ert		Gootee				Г	ella		Wrot	en	
N Pu	19e. Informant's Neme/Relationshi	ip (Type, Print)				treet and	Number	-	I Route Number	er, City or T			
25 de 17 de	Mrs. Mary Lynn	Karsch-da	nughter	25	Foxalo	ve C	F . 1	Dovl	estown	PA ·	18901		
Has Has	20e. Method of Disposition		20b. F	Plece of Dispo	sition (Neme	of	,	Joya	Dete		tion - City or T	own. Stete	
mit. Pages 1 a partment of Hea portant. If Nem y Injury or othe Se.	Burial 2 Cremetion		otete _		netory or othe			7 0 5					
P Tuning	4 Donetion 5 Other (Spe		Gr		wn Cem			1-21	7-2000	Cambi	ridge,	Maryland	
my legal	21. Signature of Juneral Service Li	icensee	^	22	. Name and A	Address o	f Fecility	The	omas Fu	neral	Home	PA	
	Jene &	R Man	de	7	700 Loc	ust	St.	Cami	bridge,	MD 2	1613		
	23a. Pert1. Enter the diseese, or of shock, or heart failure. List of	complications that ca	used (1) deat	h. Do not ent	er the mode o	f dying, s	uch es c	ardiac o	r respiretory e	rrest,	1	Approximete Intervel Between	
Physician	SHOOK, OF HEART TAILUTE. EIST O	Nily Grid Coulse Gri et	oci ililo		0						1	Onset end Death	
/Medical	Immediate Ceuse (Finel disease or condition	11/1	tro str	otic	Bre	Tion	(00	(00		1	LUCAC	
Examiner	resulting in deeth)	e		or es e conseq		(000		ZUL	CO.			1900	
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executed in and intransit		b											
and and all tra	Sequentielly list conditions, if eny, leading to immediate												
	cause. Enter Underlying Ceuse (Disease or influry												
ficate be physicia ts the bu	that initieted events resulting in death) Lest		Due to (o	r as e conseq	uence of):								
Man M		d											
The law requires that the death cate has been signed by the attence page 2 should be detached for us Completed by Physician.											1		
the de ached	Pert II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying caus	se given i	n Pert I.		23b. Dld	lobacco ue	e contribute	to the cause of death?	
d by the									1 Yes 2 No 3 Probably 4				
he law requires that has been signed age 2 should be del								_					
been sign should be										en eutopsy med?	0	Vere eutopsy findings vailable prior to	
law range as be								_			0	ompletion of cause f death?	
The land age page									10	Yes 2	No 1	☐ Yes 2 No	
defant: The lav certificate has rector, page 2						26	Diego	of Dooth		,,		2,100	
Physician: this certific ral director, To Be		Hospitel:		-5.00		Other			(Check only o		704 (0	76. 5	
Physician: This certificated director, p. To Be Co.			T impatient 2 Envoutpatient 3 DOA 4 Inursing Hi						ome SQ Residence 6 Other (Specify) 28d. Describe how injury occurred				
After funer	1 Neturel 5 ☐ Pending	(Month	(Month, Dey Year) Injury Work?						200. Describe now injury describe				
tal or Attending P rs after death. al Director: After to led in by the funers Certification:	2 Accident investige	nt he					2 () 14		200 1	C		-10-1-11-1	
or At after of Direction by	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)								281. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
Within 24 hours after death within 24 hours after death completely filled in by the Medical Certifical				SILE.									
he Hospl in 24 hou he Funer pletely fil	29a. Certifier (Check only (Ch												
Plets Plets	one) and menner steted.												
To the Hospital of within 24 hours a To the Funeral D completely filled if	29b. Signature and titlerof certifier 29c. License number 29d. Date signed (Month, Dey, Year)												
)	William (201) 1)43238							- 6	Juli	125,3	2000		
	30. Neme and address of person &	ho completed cause	of deeth (Item	23e) (Type.	Print)	Lin			-			2///>	
	William 19	Dair	197	rank	100	St		(0	mbri	dae	MO	21613	
State	31. Dete filed (Month, Dey, Yeer)	32. Re	gistrat's Signe	ture	,					-	(
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341 2 5 2000 June 25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24969 Certificate of Death AMEND: #1 per PHY 7/27/00 mca 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** 24 2000 3:55 urace Grace M. Dale /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health of Glen BURNIE 6/en Buenia er If Under 24 Hrs. 8. Data of If Under 1 Ya 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foraign Country) Funeral 089-18-499 Months 1□M 250 F Days Director New York Usual Rasidence of Deceder 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits MD Anne Arundel Glen Burnie 1 ☐ Yas 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7355 Furnace Branch Road 21060 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Dates: Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indien. Bleck, White, atc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yas 2 No Specify: White à 3 ☐ Widowed 4 ☑ Divorced Completed Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If Item 27 is marked other than ?* Elementary School Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Edwin Smart Grace Horan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joan Dale / daughter-in-law 380 North Drive, Severna Park, MD 21146 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Steta July 28 1 ☐ Burial 2 ☐ Cremation 3 X Removal from Stata Johnson City, NY Floral Park Cemetery 2000 4 ☐ Donation 6 ☐ Other (Specify) 21. Signature of Funeral Service Lices Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 not entar tha moda of dying, such as cardiac or raspiratory arrast, Physician /Medical ate Cause (Final PREVMONA Exam Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown -DEMENTIA by - HISTORY OF ANGINA. 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy parformed? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: Dursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death

190 Attanding Physician: Certification: To this To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

28a-f ahow

6

Nems 23a

8

"natural",

death

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

28a. Data of Injury (Month, Day Year) 5 Pending invastigation 6 Could not be

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

(Check only one) 29b. Signatura and titla of certified

in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse number -22609 29d. Data signed (Month, Dey, Year)

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print)

7445 FURNACE BRANCH Rd 666 BURNIE MAZIOSO 31. Data filed (Month, Day, Year)

State Registrar

1 E Natural

2 ☐ Accident 3 Suicida

4 Homicide

29a. Certifier

edical



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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer BLANCHE MYRTLE DUNKIN 9:30 AM 26 2000 June /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** rahiney - Keedy Nursing Home Boonsboro Washington If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months 7 216-22-7673 Director November 18, 1905 Quincy, PA Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f show traumatic event, the Modical Examinar must be notified at MD 1 ☐ Yes 2 No Director Washington Cascade 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 25227-A Military Road 21719 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Detes: 11. Marital Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry partners of Health and Mental Hygiene sortant: if Item 27 Is marked other than "n'injury or other traumation. Elemantery/Secondary (0-12) Collaga (1-4or 5+) cafeteria worker Public Schools 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Harry H. Ray Ida May Summers 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Esther L. Lewis / Daughter P O Box 83 Sharpsburg, MD 21782 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crametory or other pleca) 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) Quilford Twp. Franklin Co. 6/28 Grindstone Hill Cemetery 22. Name end Address of Fecility Grove-Bowersox Funeral Home, Inc. 21. Signalure of Funerel Service Licensee 50 South Broad Street Waynesboro, PA 17268 Punt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or raspiratory arrast, shock, or heart feilure. List only one ceusa on each line. Approximata Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel 2-3dy congention Heart Favilor disease or condition resulting in death) Examiner Due to (or as e consequence of) no Anteno schendic buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): pue physician s the buriel Physician/Medical Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Pulmonery sincer China solundin by 24b. Wera autopsy findings avelleble prior to completion of cause of death? Completed In which was 24e. Was an autopsy performed? Mellitas 1 Yes 2 THO 1 ☐ Yes 2 ☐ No this certificate 25. Wes case referred to medical examiner? 1 1 765 2 No Be 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending Investigation 1 ANaturel 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide

Duncan Blanche To the Hospital within 24 hours e To the Funeral Completely filled

Slande m.

State Registrar

29e. Certifier

29b. Signeture end title of certifier

- (Dad MO 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Datta 334 Mill Street Hagerstown, MD 21740

32. Registrer's Signature 31. Dete filed (Month, Dey, Year) JUN 2 2000

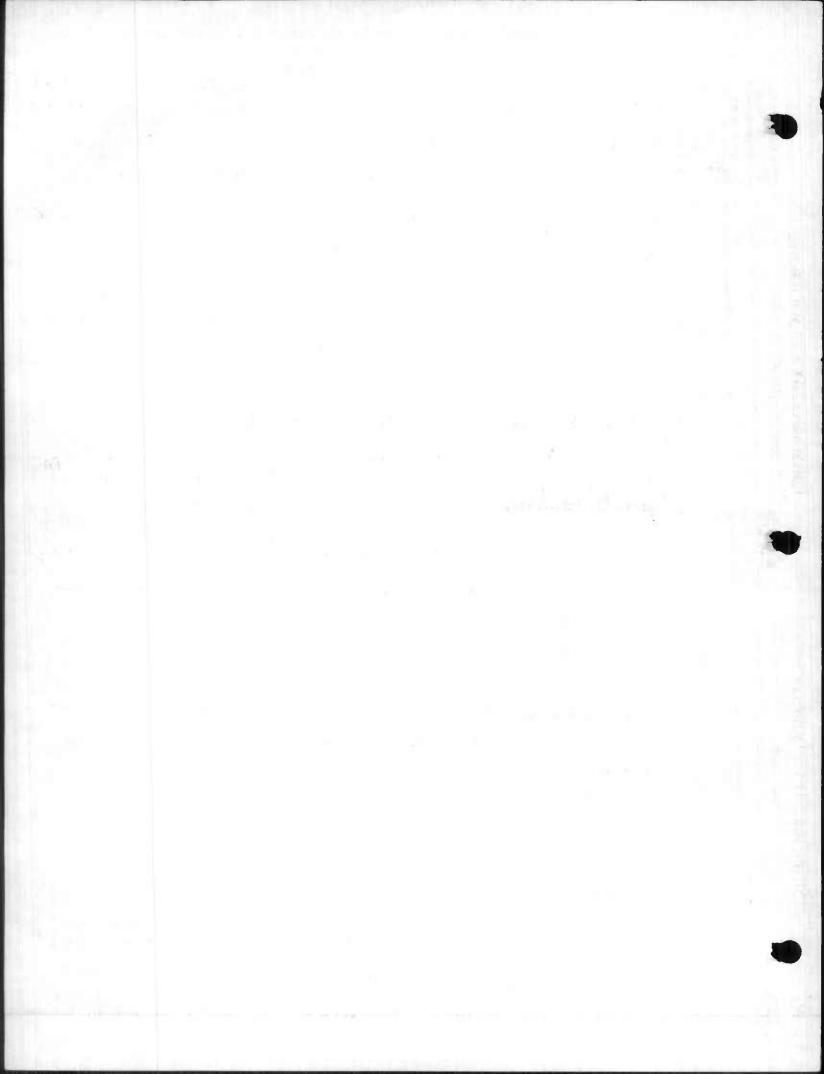
1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29c. License number

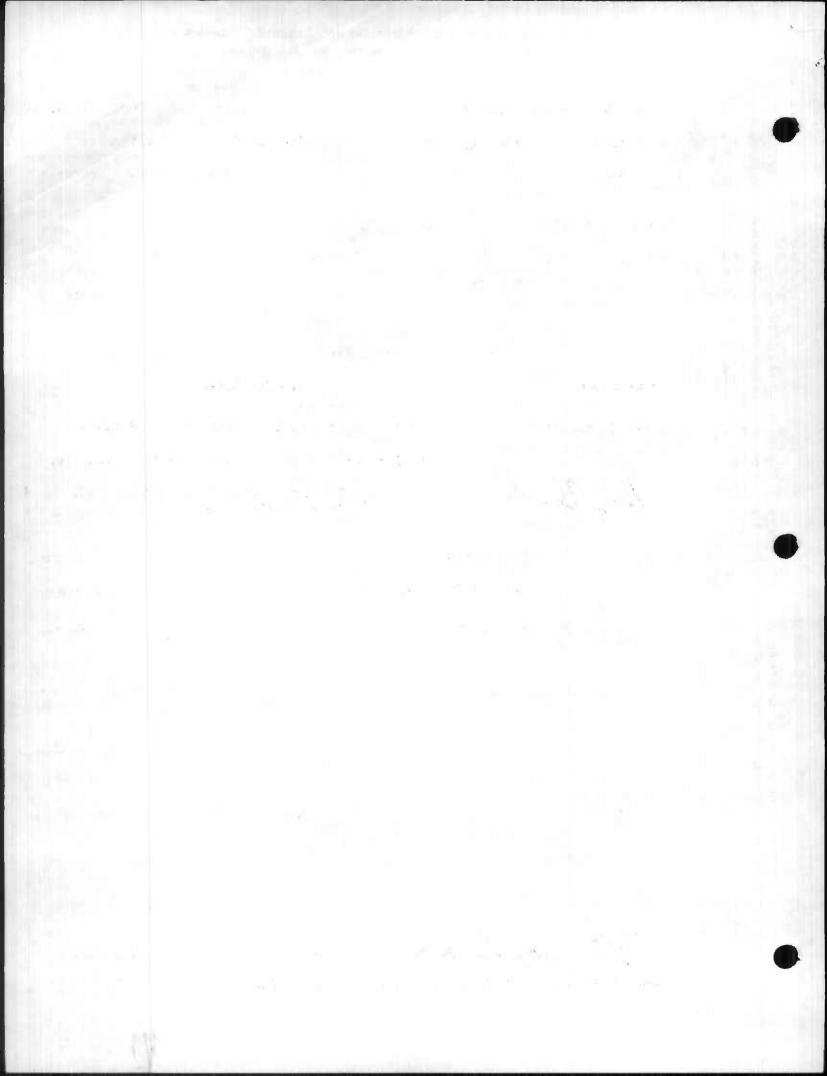
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29d. Date signed (Month, Dey, Year) JUNE 26, 2000



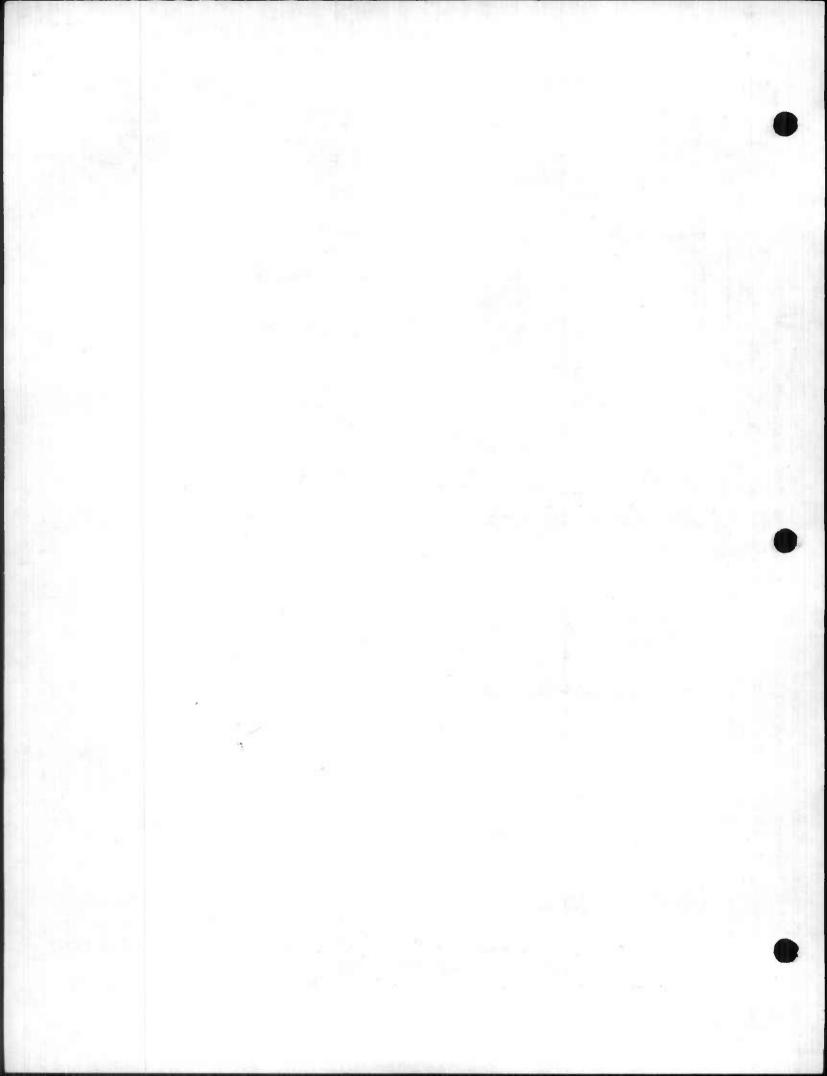
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				ai yiaii	Certif	icate of	Death	, , ,	Reg. No.	2	4971.
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Physicia /Medic	_	BETTY FRAN	CES EAST	ON				July		000	11:45
Examine	_	4e Fecility Neme (If not institution, give	street end number)				4b. City, Town, or I	Location of Deat	4c. County	of Death	
		Fairland Adventi	st Nursin	g Hon			Silver S			tgome	
Funeral		Sociel Security Number 8. Security Number	ex 7. Ag □ M 2 0 XF	ge (In yrs. i	N	lunder 1 Year lonths Deys		(Month, De	th y, Year)	9. Birthpli Count	ece (Stete or Foreig
Director	-	230-48-9463	- M 2 CA	91	Yrs.			Sep. 2	21, 1908	N	lebraska
pug *	1	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City	y, Town or Locati	ion				10	Od. Inside City Limits
faryld Febo	5										1 XYes 2 No
the A	Director	Virginia Fairfa 10e. Street end Number	X	Vi	enna	10f. Zip Code			10g. Citizen of V	Vhet Count	10/2
with a s	ត់		TY			22180	6250		USA		
eeth	era	706 Ware St., S.	W . 12. Was Decedent	Ever in U.	S. 13. Was			specify Yes or No		e - America	en Indian,
020 urs s	by Funeral	1 Never Married 2 Merried 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Yes 2 X No	Hispenic Origin? (S ban, Mexican, Puerl Specify:	to Rican, etc.)	Specify Specify	k, White, e	hite
5-0 72 ho	E E	15. Decedent's Ed (Specify only highest gra	ucetion	Harry I	16e. Deceden	i's Usuel Occu	ipation	rkina	16b. Kind of Bu	siness/Ind	ustry
within 7 ena.	Completed	Elementery/Secondary (0-12)	College (1-4or	5+)			ed) during most of wor				
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Du di di di di di di di di di di di di di	Be	17. Fether's Name (First, Middle, Last)							, Meiden Surnem	e)	
ylan ould be Mental arked o	L C	Jerome Stanek					Veronik				
Aar 2 sh 1s m		19e. fnforment's Neme/Reletionship (7	ype, Print)		19b. Mailing A	Address (Stree	et end Number or Ru	urei Route Numb	er, City or Town,	Stete, Zip	Code)
and and mark		Robert B. Easton	/Son	look p	706 W	are St	., S.W.,	Vienna,	Va. 221 20c. Location -	80-63	50
Baltimore, semit. Pages 1 ar Department of Hea mportant: If item: any Injury or othe		20e. Method of Disposition 1	Removal from State	0	emetery, cremet	ory or other pl					
Famen ment: Part: Jury		4 ☐ Donetion 5 ☐ Other (Specify		Nat	ional M	emoria	1 Park	7/20/00	Falls	Churc	h, Va.
	[A]	23a. Pert1. Enter the Cheese, or companies, or heart feilure. List only	olicetions thet ceuse one ceuse on each li	d the deeth	n. Do not enter t	MONEY 171 W. he mode of dy	& KING VI Maple Av ving, such es cerdia	ENNA FUN e., Vier c or respiretory e	NERAL HO	ME, I 2218	NC. O Approximete Intervel Between Onset end Death
Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	e. Dehydra							2	2 Months
	ē		Organic		rese conseque in Syndr						3 Years
uted	Examiner	Sequentially list conditions	b. Organic		r es e consequer						lears
axec an en riel-tr	EX	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	D1 - 1	•	restriction and and						
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Vital I	BeC	25. Wes case referred to medical					26. Place of De	eth (Check only	one)		
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On Of dling Phys th. After this funeral d		27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Inju (Month, De	ny Year)	28b. Time of Injury	28c. Inj W	ury et ork?	28d. Describe	how injury occur	red	
Division or or the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		jury - At ho c. (Specif)	ome, ferm, street	, factory, office	ð	28f. Location (City or To	Street end Numb wn, Stete)	per or Rura	l Route Number,
Hospital of 24 hours a se Funeral of Pletchy filled	edicai	29a. Certifier (Check only one) 1 Certifying Ph	vsician: To the best liner: On the basis o end menner st	f examine	wledge, death od tion end/or inves	curred et the tigation, in my	time, dete end plece opinion, deeth occu	e, end due to the urred et the time,	ceuse(s) end me date end place,	enner as st end due fo	eted. the ceuse(s)
within 2 within 2 To the	Me	29b. Signeture end title a certifier	, 1			29c. Licer	nse number		29d. Date signe	d (Month, i	Dey, Year)
		1 Sand	M/L	N	M	D54	4488		Ju1y	21. 2	000
10	1	30. Neme end address of person who	completed ceuse of c	deeth (Item	23e) (Type, Pri				July	, 2	
		Bennett So, MD	8317	Cherr	y Ln, L	aurel,	Md. 2070	7			
Stat		31. Dete filed (Month, Dey, Year)	32. Registr	rer's Signa	ture 4	loon	61				



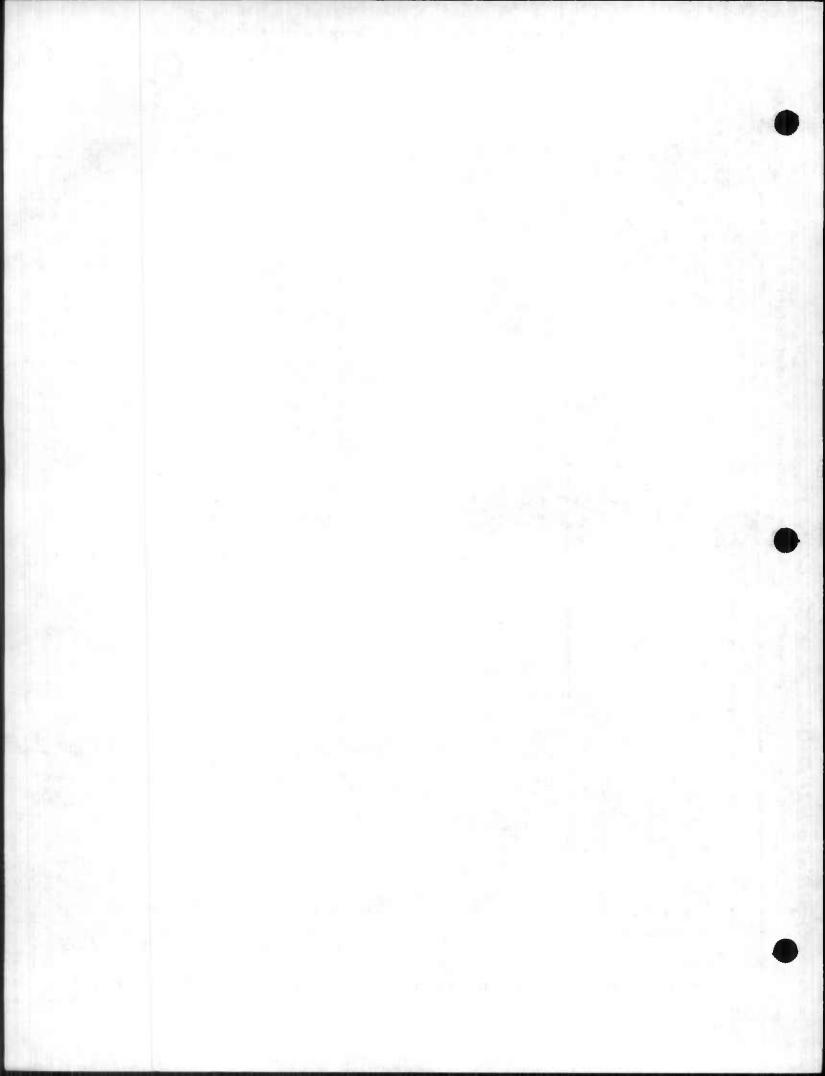
State of Maryland / Department of Health and Mental Hygiene

				Cert	ificate of	Death	F	leg. No.	1 24972.
	D h	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physician /Medical	Dora Meyers Edel	man				July	27, 200	0 11:10 AM
	Examiner	4e Facility Name (If not institution, give s	treet and number)			4b. City, Town, or I		4c. County of	
		Casey House			William	Rockvil		Montg	
	Funeral Director	056-03-2699	7. Age (In yrs. 86	V	Months Days		8. Date of Birth (Month, Day Mar. 2]	Year) 1914	New York
	P	Usual Residence of Decedent 10a. Stata 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
	or 28a-f shi be notified a	MD Montgom	ery R	ockvill					1∰ Yes 2□ No
	er death with the Mayla herra 23a or 28e-f show ner must be notified at 'unieral Director	10e. Street and Number 12802 Parkland Dr				853		U . S	
Maryland 21215-0020	Mr. or	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		as Decedent of l Yes, specify Cub ☐ Yes 2⊠ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Rican, etc.)	14. Race Black, Specify:	American Indian, White, etc. White
5-0		15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decede	ent's Usual Occu	pation during most of world)	king	16b. Kind of Busin	ness/Industry
121		Elementary/Secondary (0-12)	College (1-4or 5+)			ed)			
12	led withir tygiene. her then nt, the Ma	12 17. Father's Name (First, Middle, Last)		Но	memaker	18 Mathada Nas	o /First Middle	Own Maiden Sumama)	Home
an	the se of the se						Rothbla		
7	Mould Men marke marke To	Joseph Meyers 19a. Informant's Name/Relationship (Typ	ne Print)	19h Mailing	Address (Stree	t and Number or Ru			ata Zin Code)
Me	and 2.	Bernard Edelman/				nd Dr., R			
re,	一工 至春	20a. Method of Disposition	20b. F	Place of Disposi			Date	20c. Location - Ci	
Baltimore	tt. Pages rtment of rtant: If Ib	1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Jue	dean Me	morial (Gardens	July 28, 2000	01ney	, MD
Ba	Depa Depa Impo any I	21. Signature of Funeral Service License	5		Name and Address Zansky- O Rockv	Goldberg ille Pike	Memorial , Rockvi	Chapels	inc. 20852
		23a. Pert Phter the disease, or complic shock, or heart failure. List only one	alions that caused the deet						Approximate Intarval Between
	Physician								Onset and Deeth
A	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Parkin	son's D	isease				years
		resolving in deatil)	Dua to (c	or as a consequ	ence of):				
П	axecuted an and rel-transit	b.	Due to le	or as a consequ	ones a0:				
60,	g physician and as the burlet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Doa to (c	as a consequ	erios orj.				
68760,	5 0 6 2	that initiated events resulting in death) Last	Due to (o	r as a conseque	ence of):				
Вох	at the death cert d by the attendin etached for use Physician/W	d.	V						
	a das he at sec	Part II. Other significant conditions cont	ributing to death but not ras	ulting in the und	derlying cause gi	iven in Part I.	23b. Did to	obacco use contr	ibute to the cause of death?
P.0.	that the ned by the detache						101	'es 2⊠ No 3	Probably 4 Unknown
Vital Records,	s been sign 2 should be pleted by	X 1 - 3 - 3 - 3 - 5					24a. Wes a perfor		24b. Were autopsy findings available prior to completion of cause of death?
Ě	The law page 2	LUMBER OF STREET					1 D Y	es 2⊠No	1 ☐ Yes 2 ☐ No
/Ita	ysicien: The is certificate director, pag	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only or	ne)	
of <	2 00 5	1 ☐ Yas 2 ☑ No	ospital: 1 Inpatient 2	ER/Outpatient	3LI UUA		ome 5 Resid	ence 6 🖺Other	(Specify) Hospice
U	thar ti uners	27. Manner of Death 1 Naturat 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. tnju Wo		28d. Describe h	ow injury occurred	
Sio	Attending or deeth. ector: Aftai by the fune fune fillcation	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	001.1		0.10
-	tal or Attending P is after deeth. Is Director: After t led in by the funera Certification:	4 Homicide detarmined	28e. Place of Injury - At he building, atc. (Specif	ome, farm, stree y)	et, factory, office		City or Tow		or Rural Route Number,
	To the Hospital or Attending Phy within 24 hours after deeth. To the Funeral Director: After thi complataly filled in by the funeral Medical Certification: 7	(Check only 2 Medical Examine	cian: To the best of my kno er: On the basis of examina						
	thin 2 the mplet	one)	and manner stated.						
	5 ¥ 5 0 0 €	29b. Signature and title of certifier		nD		SOYL			Month, Day, Year) 7 (2362)
	18	100100	7		- 1	2270		my 2	
		30. Name and address of person who com Stephen Newman, 1				Rockvil1	e, MD 20	0855	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture /	1				
	Registrar	JUL 2 8 200	O pereva	D.	spork.	2			



State of Maryland / Department of Health and Mental Hygiene 00 24973

150			Cei	tificate of	Death	F	Reg. No.	24010				
Dharatatan	1. Decedent's Nema (First, Middle, Las	ith Day Yes	3. Time of Death									
Physician /Medical	Barbara R.	Enten				July	23 200					
Examiner	4a Facility Name (If not institution, give	street and number)	4314		4b. City, Town, or	Location of Death	4c. County of D	eath				
	Suburban Hospita	1		100	Bethe	sda	Mont	gomery				
Funeral Director	5. Social Security Number 6. So 579–46–6339	9x 7. Aga (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days			1931 M	Birthplace (State or Fore Country) lary Land				
D.	Usual Residence of Decedent											
death with the Menyland ms 23s or 28s-f show ms to notified s neral Director	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Lin				
ct de M	Maryland Montgome	ery B	ethesda					1 ☐ Yes 2 [7]				
or 20	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?				
15 W 1	5305 Wilson Lane			2081	4		USA					
or; or its	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Dacedant Evar in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cui I ☐ Yes 2 ☑ No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Raca - A Black, W Specify: T	merican Indian, /hita, etc. White				
72 hours natural', deal Ex	15. Decedent's Ed		16a. Deced	lent's Usuat Occu	pation duning most of wored)	rkina	16b. Kind of Busine	ess/Industry				
_ = =	(Specify only highest grad	Coilege (1-4or 5+)	life. l	DO NOT use retin	ed)	ning						
Digital of	Elementery/Secondary (0-12)	2		Homemak	er		Own Ho	me				
d other	17. Fathar's Nama (First, Middla, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	12 62				
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The state of the s	Frank Enten / Hus						laryland					
Health Park	20a. Method of Disposition			sition (Nama of natory or other pla		Data	20c. Location - City					
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Department of Health and Mental Hygion Important: if item 27 is marked other th any injury or other traumatic event, the pack	Parklawn Memorial Park 07/27/00 Rockville, Maryl 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904											
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Dage he	hymerto	10.4.1.21				101	res 2 No	1□Yes 2□No				
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Z Compa	29b. Signature and title of cartifier	in -	Physica	29c. Licer	nse number 005326	. 1		lonth, Day, Year)				
	30. Name and address of person who o	completed cause of death (Ite	em 23a) (Type,	Pille,	# 103,	Rocki	ell Mi	20852				
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	natura 4	Some	21							

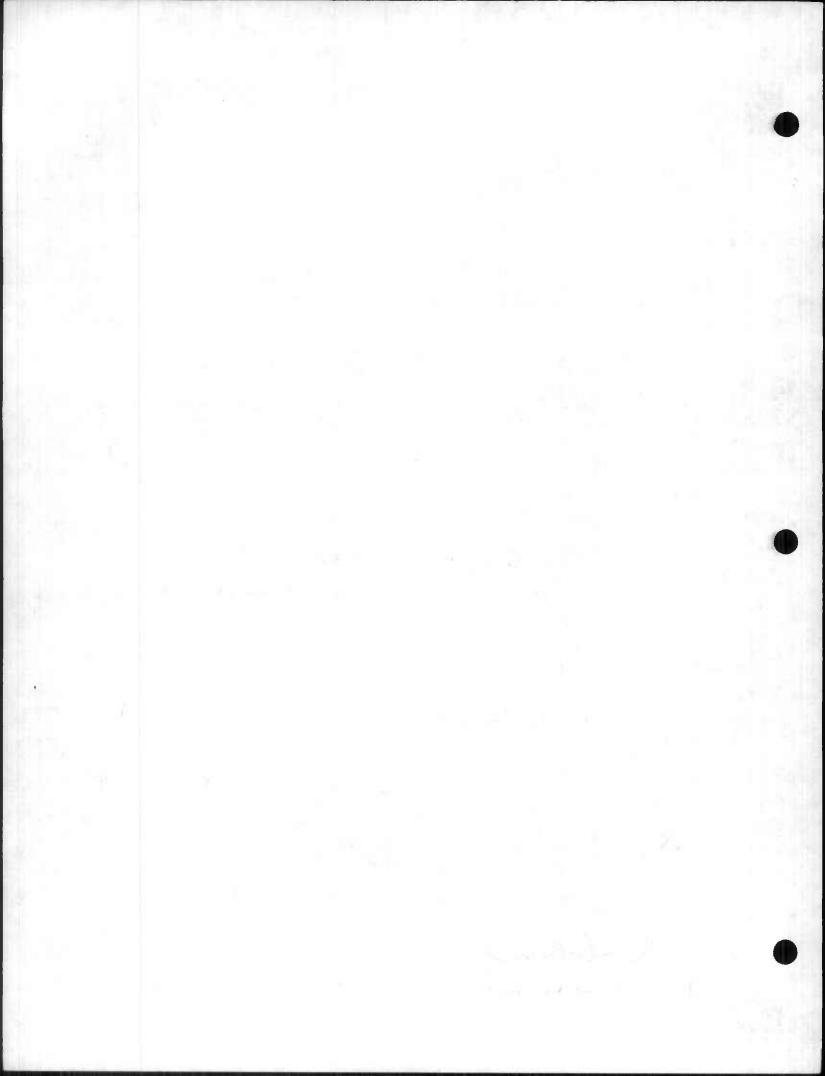


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

artment of Health and Mental	Hygiene	00	249
rtificate of Death	Dea No	00	243

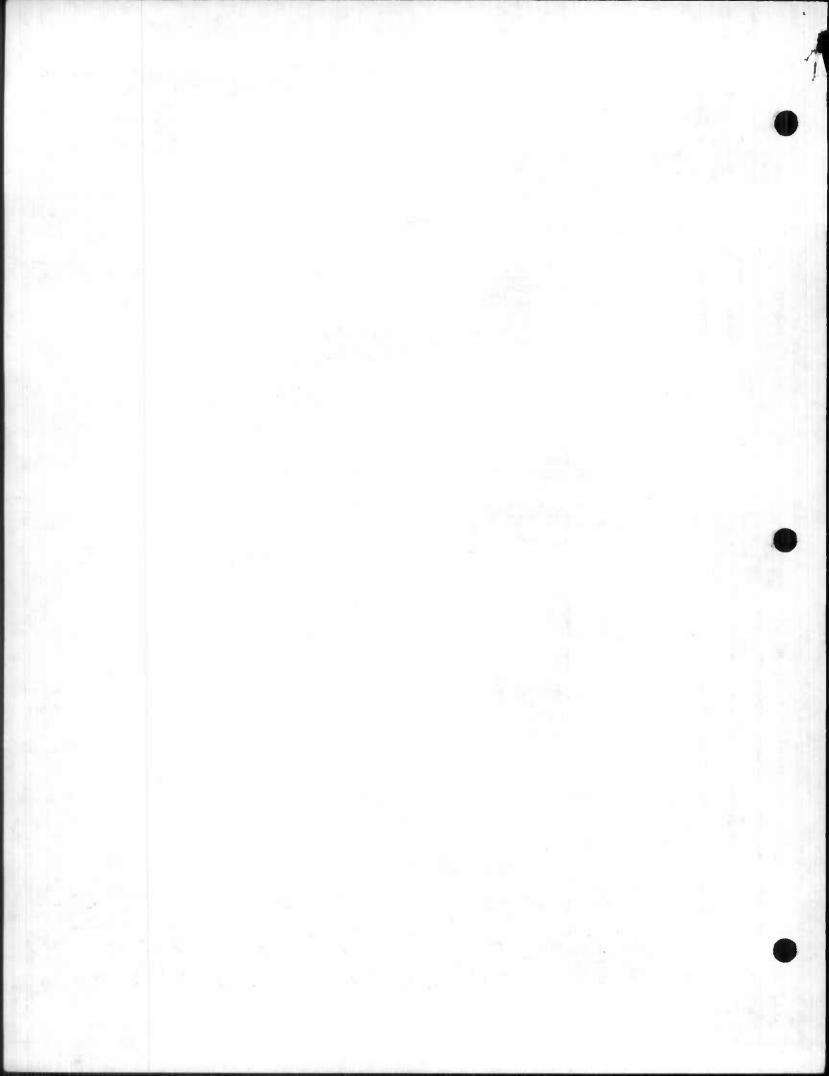
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The State of Course of Marine Grant Course of Marine Cour			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Under 1 Year 11 Months Days 12 Months Days	If Under 24 Hrs 8 Date of Birth	9. Birthplace (State or Foreign
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22. Name and Address of Facility Lyles Funeral Service P.O. Box 397, Purcellytille, VA 20134 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of the such silver. Clause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of the such silver. Clause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of the such silver. Clause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches and Death of the such silver. Clause (Final disease, or conditions, as which is a consequence of): Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part II. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 10 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part II. 11 Part II. Other eignificant conditions. 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy performed? 22b. Was an autopopy perform	nore,	ages 1 a nt of Hai till tham y or othe	1X Burlal 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		
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Spool of the state	B.	death d for i	Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23b. Dld t	obacco usa contribute to the cause of death?
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.		offing th.: After a fune	1 Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Year		
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O.C.M.E. JULY 25,2000 30. Naiwand address of person who completed cause of death (Item 23a) (Type, Print) To All Month Day York (All Month Day York) 23. Date filed (Month Day York) 24. Date filed (Month Day York)		A Hospitu 24 hours Funera Metaly fille	1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examinar: On the basis of examination end/or investigation, in my opin and manner stated.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201			29c. Signature and title of ceptifier 2		
24 Date filed (Manth Day Vac) 29 Datistants Classifier		~		le Lie	1011 23,2000
		State		Street, Baltimon	re, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #10c.7/28/2000, BMW, Montg. Co. 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death Month Day **Physician** Josephine Gilham Fath July 23, 2000 11:20 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing and Wellness Center Rockville Montgomery 5. Social Security Number 6. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 201F Min. Dec 10, Director 88 228-22-5718 Usual Rasidence of Decede Ohio the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglone. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madral Example motified any one. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Columbus 1 ☐ Yas Ž No Director Ohio Franklin Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 563 Acton Road 43214 Funeral USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fiscal Officer Federal Government 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be 2 Catherine Ahern Edwin Gilham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Fath/ Son 2037 Westchester Drive, Silver Spring, MD 20902 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/26/00 Columbus, Ohio Resurrection Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W, Silver Spring, MD 20901 Approximate Intarval Between Onset and Death a death. Do not entar the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 24 Examiner Due to (or as a consequence of): Examin attending physician and for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 an/Medical Dua to (or as a consequence of): detached 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown bengis teb ed b p 24b. Were autopsy findings available prior to completion of cause of death? eted 24a. Was an autopsy performed? Compl page 2 ils certificate h director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Horne 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funaral 28a. Data of Injury (Month, Day Year) 27. Manner of Death ne Hospital or Attanding Ph n 24 hours after death. The Funeral Director: After the pletaly filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending invastigation 1 Yas 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) > 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Co., Rockerille MD 20850 Rurt I. Feldman MD Barren 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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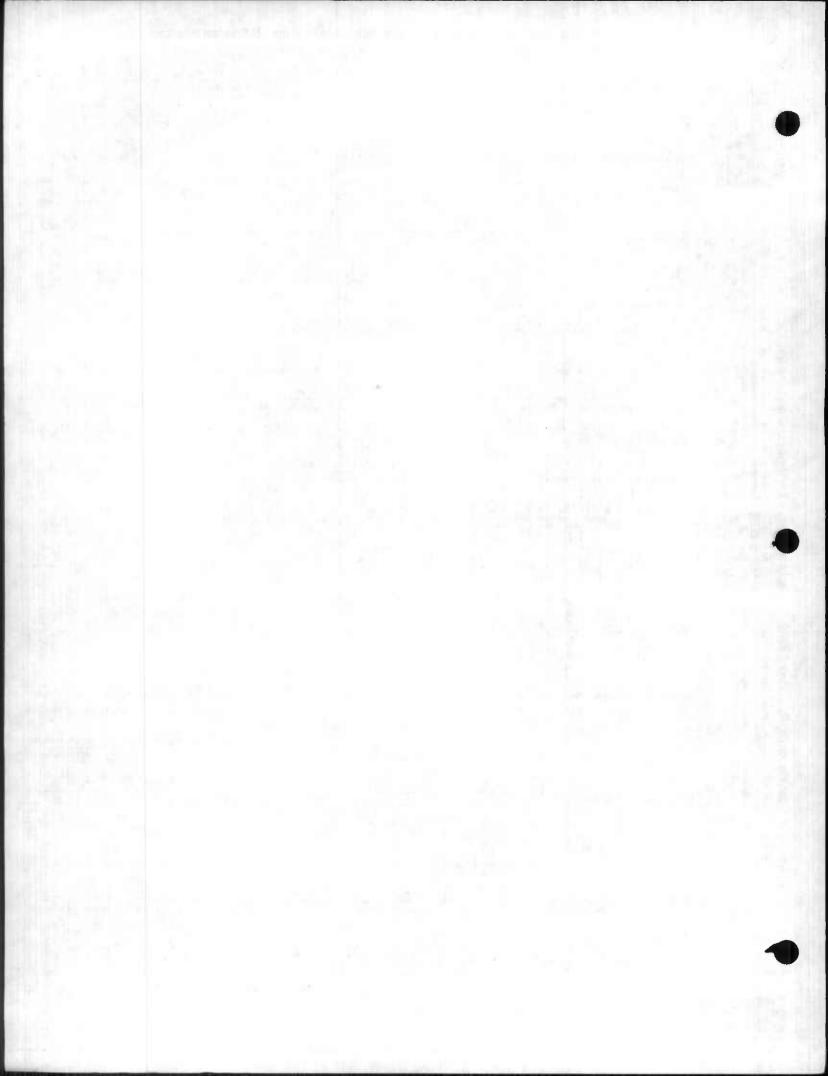
Registrar



State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of	Death		F	leg. No.	U	249	16
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	/Medical Examiner	4e Facility Neme (If not institut	ion, give street end numbe	er)	COLUMN TO		4b. City, To	wn, or Lo	cation of Death	4c. County			
		Washington A	dventist Hos	pital			Tako	ma I	Park	Mont	gome	ry	
	Funeral Director	5. Social Security Number N/A	-	Age (fn yrs. last bi	Yrs. If Unde Months	1 Year Days	If Under:	24 Hrs. Min. 10	8. Date of Birth (Month, Dey July 18	Year) 2000	Coun	place (Stete or otry) ylnad	Foreign
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Maryland 21215-0020	burs after death with the Maryla rat', or iteme 23a or 23a-1 show Examiner must be notified at by Funeral Director	11. Merital Status 1 Never Married 2 Merital Merital 4 Divorce	If Yes, Give	s? ☑ No					ecify Yes or No- Rican, etc.) vadorea:	Bled	e - Americ k, White, His		
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	/Medical Examiner	Immediate Cause (Final disease or condition	Res	piratory	Failure	2						10 mi	n.
		resulting in death)	a .		consequence of)								
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5	Physician: r this carific ral director.	1 ☐ Yes 2 🎇 No	Hospital:	atient 2 ER/O	utpatient 3 D	OA Oth	ner: 4□ Nu	irsing Ho	me 5 Resid	ence 6 Oth	er (Specif	(y)	
	ath. r. After th e funeral	27. Menner of Death 1 XNatural 5 Pend 2 Accident	28a. Date of li (Month, i		Time of Injury M	28c. fnjui Woi 1 🗆	yat rk? Yes 2⊡	No	28d. Describe h	ow injury occur	red		
Division	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 206. Plece of	Injury - At home, for etc. (Specify)	erm, street, factor	y, office			28f. Location (S City or Tow		er or Rure	el Route Numi	ber,
	he Hospitu in 24 houn he Funera pletely fille edical (29a. Certifier 1 Certify (Check only 2 Medica	ring Phyafcian: To the be at Examiner: On the basis and menner	of examination ar	e, death occurred nd/or Investigation	et the tir n, In my c	me, dete en opinion, dea	d plece, th occur	and due to the c red at the time, c	cause(s) end me dete and place,	enner as s and due to	iteted. the ceuse(s))
	withir To the comp	29b. Signature and title of certif	ier ///		29	c. Licens	se number		2	29d. Date signe	d (Month,	Day, Year)	
		Me em	home	M. N.		12/	826	9		7/21	400	2	
		30. Neme end address of person	on who completed cause of	of deeth (Item 23a)				1		1	1		
		Benson Silve	rman, M.D.	; 7600 Ca	erroll A	ve.,	Takor	na P	ark, M	20912	2		
	State Registrar	31. Date filed (Month, Day, Yes	32. Regi	strar's Signeture	9. Sp	uks	,						

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

00 24977

				C	ertificat	e of	Death			Reg. No.		L 101.		
1. Decedent ian	's Name <i>(First, Mide</i> I	die, Last) SABELLE	LE	NA FRI	TZ				2. Date of De Month	Dey	Yeer	3. Time of Death		
	lame (If not Instituti	on, give street a	nd number)		1000		4b. City, To	wn, or Lo	cation of Death					
	NSULA REG	IONAL MI	EDICAL	CENTER			SALI	SBUE	RY	WICO	OMICO			
5. Social Se	curity Number	6. Sex		(In yrs. last birthd	ey) If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da			place (State or Foreigntry)		
216-	-38-8492	1□M 20	₽F {	38 Yrs	NOUTE	Days	Hours	WIII I.	May 2			yland		
	ence of Decedent													
10a. State	10b. Count			10c. City, Town o							1	Od. Inside City Limit		
MD	Dor	chester			Can	nbrid	dge			t ≠ Yes 2				
10e. Street a	and Number		ME III		10f. Zip	Code		3.73	3 /23	10g. Citizen of \	What Cour	ntry?		
	306 C	rusader	Rd.		21	613			25 11	U.S.A	A.			
11. Meritel S	Stetus		s Decedent E	ver in U,S.	3. Was Dece	dent of H	lispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Rac	e - Americ	ean Indien,		
	er Married 2 Ma	rried 1 🗆	Yes 2 No	0	1 ☐ Yes		Specify:	, 1 00.10	Thours, oto.,			oto.		
3 ☐ Wid	owed 42 Divorce		r or Dates:		10 100	2 2 140	Specify.			Specify	whi	te		
	15. Deceda (Specify only high	nt's Education	(atad)	16a. De	cedent's Usu	al Occup	ation	t of worki	ina	16b. Kind of B	usinass/in	dustry		
Elementa	ry/Secondary (0-12)	1	lega (1-4or 5+	-)	ive kind of wo		d)	t or works	9		71			
	11				caregiv	ær				home	home health			
17. Fether's	Neme (First, Middle	e, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Suman	ne)			
	Har	ry E	Lmer	Blades				I	Amanda	Angeli	ine	Hughes		
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State,												Coda)		
Shir	ley White	- niece	9	31	708 Di]	Lwort	th Ave	2 5	Salisbu	ry MD 2	1804			
20a. Method	of Disposition			20b. Place of Di		me of			Date	20c. Location		own, Stete		
	rial 2 Cremation		from State					ark	7-28-00	Cambrio	dae.	Maryland		
	re of Funeral Service				22. Name ar	-		1						
1		enna		1				11		uneral H		PA		
	fracto	KIR	have	1						MD 21613	3			
23a. Part1. shock,	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
	Onset and Death													
Immediate (Immediate Cause (Final disease or condition a Arterior Corotec Heert Risease Mys.)													
disease or condition resulting in death) Due to (or as a consequence of):														
Due to (or as a consequence or):														
Sequentialh	/ list conditions.	b	С	oua to (or as a con	saquance of):									
if any, teadi cause. Ente	y list conditions, ng to immediate or Underlying ease or Injury I events													
that initiated	ease or injury	C	D	ue to (or as a con	sequenca of):						-			
1050iting iii	ooduly Last	1000												
		d									1			
Pert II. Other	r significant condit	tions contributing	a to death but	not resulting in th	e underlying o	cause giv	ven in Part I		23b. Dld	tobacco uae co	entribute t	o the cause of deat		
R	0	4	E	0.		2	.4-1	-0-		Yee 2□ No	3 □ Pro			
1/2	veno	uerc	1 4	tema.	- my	rec	May	re	-	100 2010		, , ,		
/		- 1	2.						24a. Was	an autopsy	24b. W	ere eutopsy finding		
K	enel	tart	ripe						perfo	ormed?	CC	vailable prior to empletion of cause		
												death?		
									10	Yes 2 No	1	☐ Yes 2☐ No		
25. Was cas examine	sa referred to medic	-			- 2702	100		of Deatl	h (Check only o	ona)				
1 Tes	2 1No	Hospital	1 Inpatien	t 2 ER/Outpe			4 LI NU	irsing Ho	me 5 Resi	dence 6 □Oth	ner (Speci	fy)		
27. Manner			Date of Injury (Month, Day	Year) 28b. Tim	e of	28c. Injui Wor	ry at rk?		28d. Describe	how injury oocu	rred			
2 Acc	ident invas	tigation			М	1 🗆	Yes 2	No						
3 ☐ Suid		mined 28a.	Place of Injurbuilding, etc.	ry · At home, farm	street, factor	y, office			28f. Location (City or To		ber or Run	al Route Number,		
			bulloling, oto.	(opoony)						,,				
29a. Certifie				my knowledga, d										
(Check one)	only 2 Medica	il Examiner: On and	the basis of e d manner stet	examination and/o ed.	r investigation	i, in my c	opinion, daa	ith occurr	ed at the time,	date and place,	end due t	o tha cause(s)		
29b. Signatu	re and little of certif	ier	1		29	c. Licens	se number			29d. Date signe	ed (Month,	Day, Year)		
X	108	eres	1		7	7	71.71	2	100	7/2	10	D		
20.51	1000	- 9e	100	THE PARTY AND ADDRESS OF	17	7/	6/6		01	4 119	10	- 0		
30. Name at	id address of Dirso	n who complisted	o cause orde	ath (Item 23u) (Ty	pe, Print)	2	0.17	me	14	ujs	100	-		
21 22	d (Manth D)	. 000	ng	9/72		rek	ish	un	111	wil.	219	501		
31. Dete file	d (Month, Dey, Yea		32. Registra	s Signature	4	1	14/10	0						
	JUL	2 7 200	0 7	-	P.	200	ala/							

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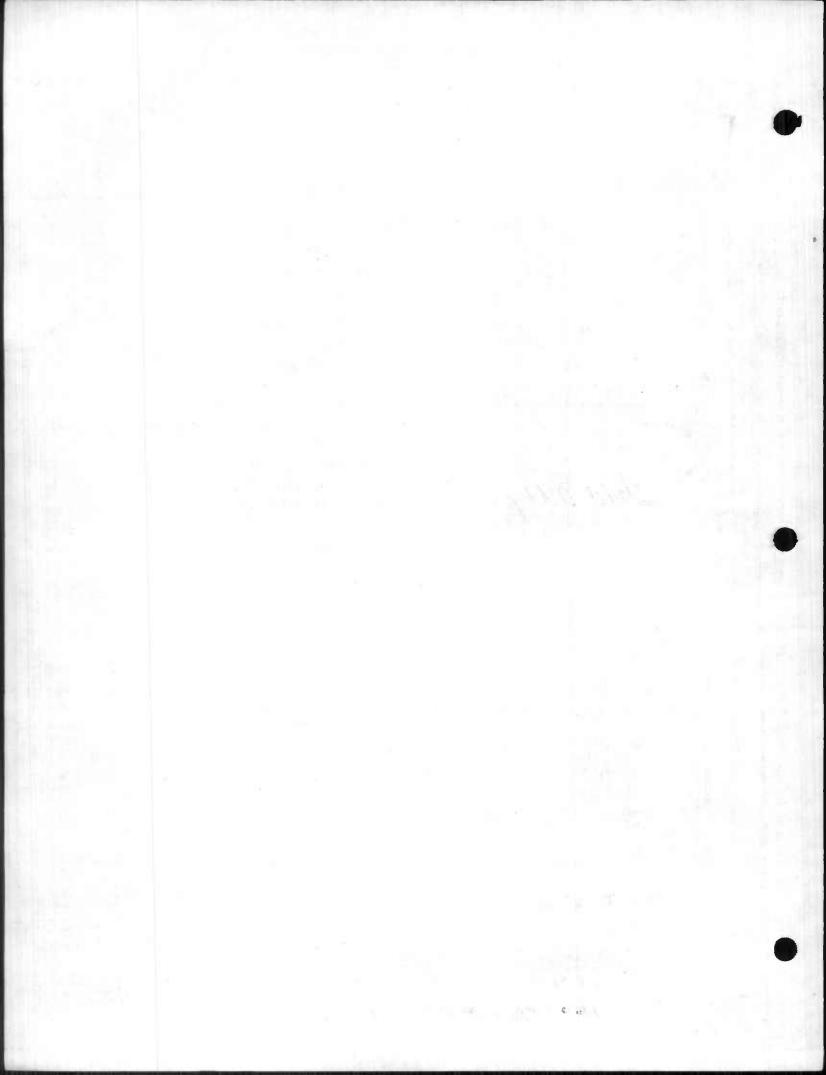
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		tato of Maryland		ate of Death	,	Reg. No.	1 21,070			
Physician	Decedent's Name (First, Middle, Last)				2. Dete of Dee Month		3. Time of Death			
/Medical		lelen Lorrain	ne Fitzsi		June	17 20	1			
Examiner	4a Facility Name (If not institution, give street		1 0 1 1		r Location of Death					
Funeral	Shady Grove Adventis 5. Social Security Number 6. Sex	7. Age (In yrs. in	st birthday) If Un	Rockv der 1 Year If Under 24 Hr	s. 8. Date of Birth		kville 9. Birthplace (State or Foreign Country)			
Funeral Director	218-20-0862		Yrs. Monti	hs Days Hours Mir	April 1		Maryland			
danyland f ahow	10a. State 10b. County Maryland Montgome		Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
or 28a-f a	Maryland Montgome 10e. Street and Number	ily Gern	nantown 106.	Zip Code		10g. Citizen of Wh	nat Country?			
Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa S	19209 Bonmark Court			20874		United	States			
II X I D-UUXU within 72 hours effer death with the Manyland ans. than "natural", or items 23s or 28s-f ahow than "natural", or items 23s or 28s-f ahow than predict and the notified at predicted by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1000	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indien, White, etc. White			
1 Z 1 Z 1 D-UUZU od within 72 hours eft yojens. ver than "natural", or it, the formpleted by F	15. Decedent's Education (Specify only highest grade co	on I	16a. Decedent's U (Give kind of life. DO NO	sual Occupation work done during most of w T use retired)	orking	16b. Kind of Busi				
N Der N	12		Hom	emaker		Own 1				
D # I to D	17. Father's Name (First, Middle, Last)				ame (First, Middle,					
should the market currents	Russell R. Baker				Lee Perre					
Mar d2 shc th end 7 le ma treum	19a. Informent's Name/Relationship (Type,			ess (Street and Number or I						
Health Health tem 27 other tr	Kimberly Wagner/ Dau 20a. Method of Disposition	20b. Pla	ace of Disposition (nmark Court,	Dete		Land 20074			
0 000	1 St Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	wel from State	retery, crematory	orotherplace) orial Park (/22/2000	Pooleyri 1	lo Marviland			
Galtim pemit. Pag Department Important: I any injury o	21. Signature of Furieral Service Licensee	rail	22. Name	and Address of Fecility						
Danit. Department important in processing in	> Indel 811	house		L. Moleswort						
	23a. Part1. Enter the disease, or complication shock; or heart failure. List only one care	one that caused the death.	Do not enter the n	1 Ridge Road,	Damascu:	s, Maryla rest,	Approximate			
Physician	snock; or neart tailure. List only one ca						Interval Between Onset and Death			
/Medical	Immediate Cause (Finel disease or condition	END	STAGE	RENAL	DISEA	SE	1 year			
Examiner	resulting in death) a. —	Due to (or	as a consequence	of):	*		1.40			
axecuted n and isl-transit	b	INSUL	IN DE	PENDANT	DIABI	ZTES	years			
and all-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	Due to (or	as a consequence	of):						
	cause. Enter Underlying Cause (Disease or injury that initiated events	Don't for		.0.						
2 04 2	resulting in death) Last	Due to (or a	as a consequence of	×1):			Q			
ath cert for use	d									
the death cert where the attending sched for use the school of the schoo	Part II. Other significant conditions contribu	uting to death but not resul	ting in the underlyin	g cause given in Pert I.	23b. Dld t	obacco use cont	ribute to the cause of death?			
7 4 4 5	CORONARY	ARTERY I	DISTRAS	E	101	Yes 2□ No	3 Probably 450 Unknown			
requir been s should	PERIPHERAL	VASCULA	R DIS	RASE	24a. Was parlo	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?			
The lew te has page 2	NECROTISIN	G FASCI	TIS		101	res 2 No	1 Yes 2 No			
vician: The certificate rector, pag	25. Was case referred to medical			26. Placa of D	eath (Check only o					
Physician: this certificinal director,	examiner? 1 Yes 2 No Hosp	ital: 1 ☐ Inpatient 2 ☐ E	R/Outpetient 3	DOA Other: 4 Nursing	Home 5 ☐ Resid	lence 6 Other	(Specify)			
ding Phy h. After thi funeral	27. Mapner of Death 2	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurre	d			
r Attan tar death rector: 1 by the	2 Accident investigation	8e. Place of Injury - At hor building, etc. (Specify)	M ne, farm, street, tac	1 Yes 2 No	281. Location (S City or Tow	Street and Number on, State)	r or Rural Route Number,			
Hospi 4 hou Funer tely fill	29a. Certifier 29a. Certifier 17. Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 18. Certifier 29a. Certifie									
To the comple	29b. Signature and little of certifier			29c. License number		29d. Dete signed	(Month, Day, Year)			
	Maria			D 2865	6	JUNE 20 2000				
	30. Name and address of person who comple									
	RAVI PASSI MD.	8609 SI	ECOND	AVENUE :	#404 E	3, SILV	FR SPRING			
State	31. Date filed (Month, Day, Year)	32. Registratis Signatu	100 T. A				ND 20910			

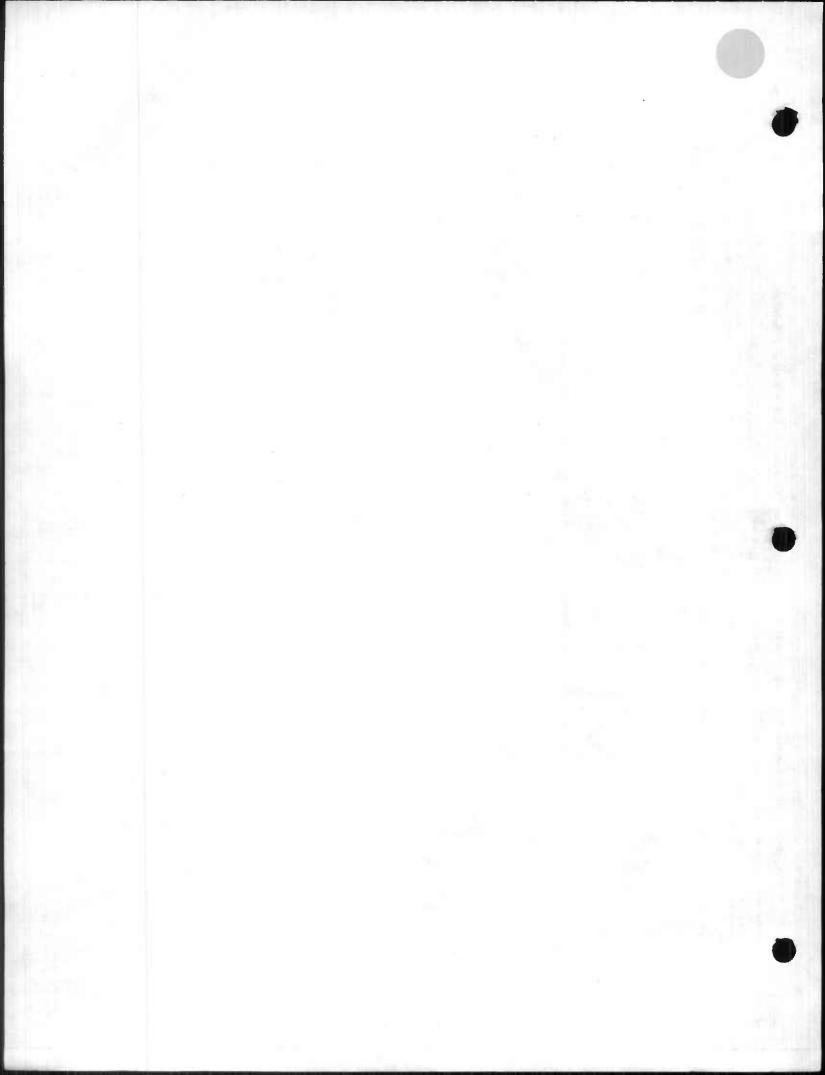
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month July 26, **Physician** Glenn Gadsden 2000 8:10 a.m. /Medical 4e Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1608 Ballard Street Silver Spring Montgomery If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) May 31, 1955 If Under 1 Yeer 5. Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⊠M 2□ F Washington, D. C 578-76-3565 45 Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director 25a-f Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð must be 20910 1608 Ballard Street United States therms 23a Funeral 14. Raca - American Indian, al Hygiene. d other than "netural", or thems event, the Medical Examiner in 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yas, Giva 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Deputy Clerk District Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is merised oth any injury or other traumaric even Be Unknown Annie Bernice Gadsden 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annie Bernice Gadsden/Mother 2125 4th St., N.W., #405, Washington, D.C. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Chesapeake Crematory Inc 2000 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Addrass of Facility
Rapp Funeral and Cremation Services 21. Signeture of Funerel Sarvice Licenses 933 Gist Ave., Silver Spring, Md. 20910 23a. Partt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Cardiopulmonary Failure Examine Due to (or es e consequence of) Examiner Lymphoma sician and burial-transit The law requires that the death certificate be executed Sequentietly list conditions, if eny, leeding to immadiete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Box 68760. Febrile Neutropenia Physician/Medical Dua to (or es e consequence of) 98 Acquired Immune Deficiency Syndrome use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Invasive Pulmonary Aspergillosis signed t Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 1 Yes 2 No 1 Tyes 2 No or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Nesidenca 8 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending 1 Natural death. 1 Tyes 2 No investigetion To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homlcide 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated. edical 29e. Certifier (Check only one) 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 17469 July 26, 2000 30. Name end eddress of person who completed causa of daeth (Item 23e) (Type, Print) Princy N. Kumar, M.D., 3800 Reservoir Rd., #110, Washington, D.C. 20007 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State oouks JUL 2 8 2000 Registrar



Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 215 Month Year **Physician** 1914 July 2000 ANNA GARDNER /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) MAR 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) Funeral Months Days 1 JM 2 F Hours Director 86 053-14-9038 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or forms 23s or 23s-f show the Medical Example; must be incitted at 1 Yes 2 No Director MD MONTGOMERY ROCKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 USA 6105 MONTROSE ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 21215-0020 Specify: WHITE 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit Pages 1 and 2 should be filed with Department of Health end Mentel Hygiene Important: If frem 27 is marked other that any injury or other treumatic event, trained to the pages. OWN HOME HOMEMAKER 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAULINE GREENBERG MEYER YEGELWEL 19a. Intormant's Neme/Relationship (Type, Print) 19b. Malting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6111 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852 FANNY WAXMAN/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JULY 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20, 2000 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) WELLWOOD CEMETERY 21. Signature of Funeral Service Licansee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical tmmediete Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence ot): pue Box 68760 one monia Physician/Medical tha Due to (or es a consequence of) USB 85 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 2 1 ☐ Yes 2 ☐ No 3 Probably Althiknown ۵. 1schemic Records, þ 24b. Were eutopsy tindings aveileble prior to Be Completed 24e. Wes an autopsy performed? completion of cause of death? page 2 1 Yes 2₽No 1 ☐ Yes 2 ☐ No certificate dy systragi-25. Was case reterred to medical examiner? funeral director, 26. Piace of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 10 of 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation Division or Attending 1. Natural 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funerel Diractor: A __completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptaca of tnjury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Insul 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) CONSUEL 2000 montes 32. Registrar's Signature 31. Dete tited (Month, Day, Year)

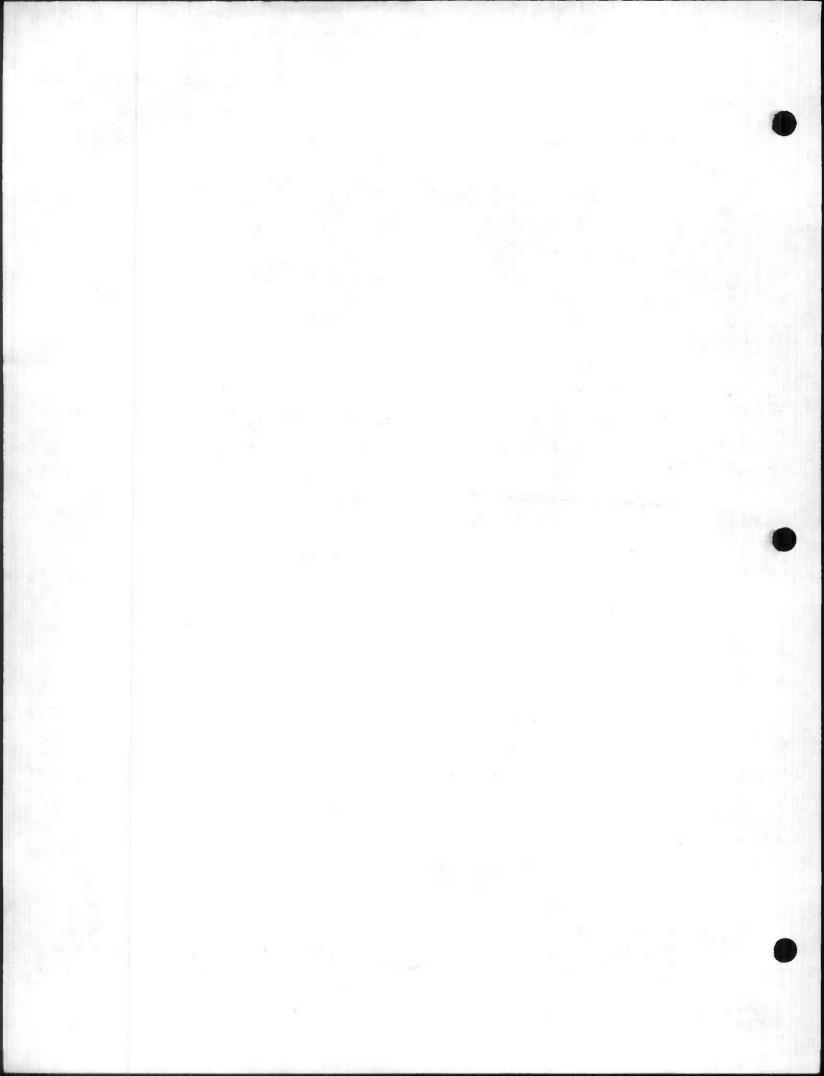
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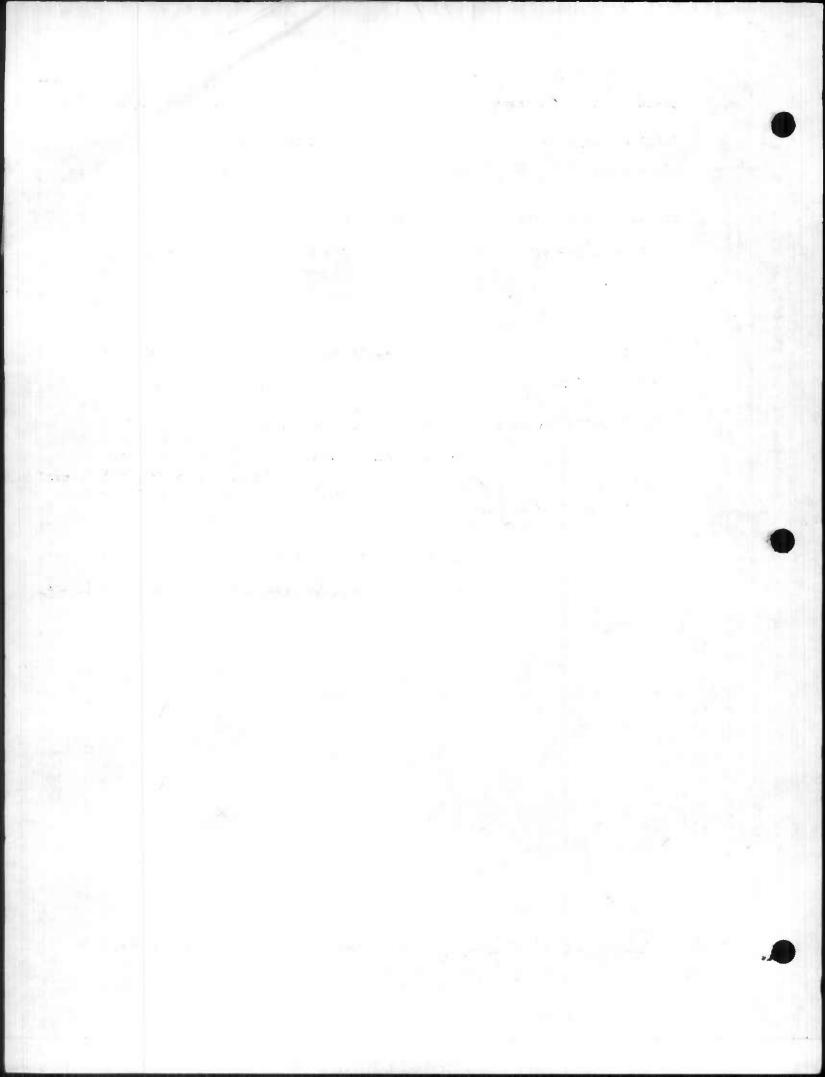
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Amend #31,s	see #32,7/25/2000,I	State of Maryla BMW, Montg. Co.		rtment of F			giene Reg. No. 0 (24982
Physician /Medical	1. Decedent's Neme (First, Middle, La Yetta B. (Goldberg				2. Date of De Month July		3. Time of Death 7:30pm
Examiner Funeral Director	4e Fecility Neme (If not institution, git 10021 Brunette A 5. Social Security Number 212-82-8143	lve	rs. lest birthdey) Yrs.	If Under 1 Year Months Deys	4b. City, Town, or Less Silver S If Under 24 Hrs. Hours Min.		Mont	gomery 9. Birthplace (State or Foreign Country) Russia
pu & w	Usuel Residence of Decedent 10a. Stete 10b. County	10c.	City, Town or Lo	cation				tOd. Inside City Limits
the Merylan r 28a-f show notined at	Maryland Montgo	omery	Silver	Spring				1 ☑ Yes 2 ☐ No
\$ 0 B O	10e. Street and Number 10021 Brunette A	ive		10f. Zip Code 209	01		10g. Citizen of Wi United	net Country? States
5-0020 72 hours after death v naturals, or theme 23s to a fauthor must sted by Funeral	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No if Yes, Give Year or Detes:		Nes Decedent of Nes Specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black	- American Indian, White, etc. White
2121 d within piene. rr than "	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5+)	life. I	lent's Usuel Occup kind of work done DO NOT use retire Omemaker		ing	16b. Kind of Bus	
Se Cath	17. Father's Neme (First, Middle, Last Aaron Brodsky				18. Mother's Nem		Maiden Sumeme nknown''	
2 should and N	19e. Informent's Name/Reletionship (19b. Mailir	g Address (Street	end Number or Run	al Route Numbe	er, City or Town, S	itete, Zip Code)
MOFe, and of Heal	Sondra Mandell/ I 20e. Method of Disposition 1 Buriel 2 Cremetion 3 I 4 Donetion 5 Other (Specia	Removel from State	o. Plece of Dispo cemetery, cren	Yellow R sition (Name of netory or other pla morial G	ose Court	Columb Dete 7/24/00	20c. Location - C	ity or Town, State
Baitimo permit. Pege: Department of Important: If I any Injury or once.	21. Signeture of Furerel Service Lice	nsee 10	22		oss of Facility St oll St. N			rial Funeral Ho C 20012
Physician /Medical	23a. Peri 1. Enter the diseese, or com shock, or heert failure. List only Immediate Cause (Final						rrest,	Approximete Interval Between Onset end Deeth
Examiner	disease or condition resulting in deeth)	Due to	o (or as a conseq	uence of):	Fail			(6 44.0)
ovecuted an and rel-transit Examiner		b	m+ 60	29426	LOSTER	> xuba	2 ome	1015
6876(licate be physicie is the bu	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Lest	c	o (or es e consequence of or established or establis					
P.O. Box eat the death certified by the attending etached for use a Physician/M	Pert II. Other algnificant conditions of	contributing to death but not	resulting in the ur	nderlying ceuse gir	ven in Pert I.	23b. Dld	tobacco use cont	ribute to the cause of death?
P. d by delay delay delay						10	Y 00 2 No	3 Probably 4 Unknown
aw requires the second as been so a should pleted					Him.		en autopsy irmed?	24b. Were eutopsy findings aveilable prior to completion of ceuse of death?
f Vitai Reystelan: The lav						10	Yes 20 No	1 Yes 2 No
Of Vita Physician: this certific ral director.	25. Was case referred to medicel exeminer?	Hospitel:		- Ott	26. Place of Deet	,		
Jing Ph Affer thi funeral	1 Yes 2 ANO 27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	4 LI Nuising no		dence 6 Other	
Division of standing P is after death. In Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined	e 28e. Plece of Injury - A building, etc. (Spe	t home, ferm, streetly)	eet, factory, office		28f. Location (: City or Tox		r or Rural Route Number,
ne Hospi n 24 hou ne Funer pletely fill edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	nysician: To the best of my k niner: On the basis of exam end manner steted.	nowledge, death inetion and/or inv	occurred at the til restigation, in my o	me, date end place, opinion, deeth occurr	end due to the red at the time,	cause(s) end men date end place, er	ner es steted. nd due to the ceuse(s)
To the To the Com.	29b. Signature and title of certifier	H. Sear	4	29c. Licens	se number	1	29d. Dete signed	(Month, Day, Year)
7	30. Neme and address of person who DR, KDG AR H. LKVI	completed cause of death (I W 9801 Grad	tem 23a) (Type, RGIA AVI	Print) Suith	3415	SILVER S	PRING N	1D 20783
State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer's Sig	5 2000	Benev	~ B.	Sport	h	10 20783



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Dey Month Year DAWNE GARNER Α. 0206 July 20 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give, street and number) 4c. County of Death RegionAL vita aure 1405 Laure 6 conces 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 24,1942 9. Birthplace (State or Foreign Country) S. CAROLINA 7. Age (In yrs. last birthday) Days Min Months Hours 103-34-4666 1 M 2 XF 58 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No P.G. LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14810 ASHFORD COURT 20707 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yas 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) HOUSEWIFE N/A 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) THADDEUS BUTTONE SR. ANNA MCKNIGHT 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEROY GARNER 14810 ASHFORD CT., LAUREL, MD.20707 20e. Method of Disposition 10 Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State HARMONY MEMORIAL PARK7/29/00 LANDOVER, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility STER FUNERAL HOME 21. Signature of Furnerel Service Licensi 3821 14TH ST. N.W. WASH, D.C. complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiretory arrest, that only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final CArdioVHSE disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

Physician /Medical Examiner

iclan and burial-transit

physician s

page 2

P.O. Box 68760,

Division of Vital Records.

or Attending Physician:

After this funaral

death.

To the Hospital or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the f

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Health in the fratural overst, the Mental Energies any finity or other traumate event, the Mental Energies.

Baltimore, Maryland 21215-0020

Physician

/Medical

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Examiner Physician/Medical þ Completed 8 Certification: To

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Were autopsy lindings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 20 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2€ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1- Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifier

29c. License numbe

29d. Date signed (Month, Day, Year)

MANY/ANY 20783

Registrar

State

edical

(Check only one)

29b. Signetura and title of certified

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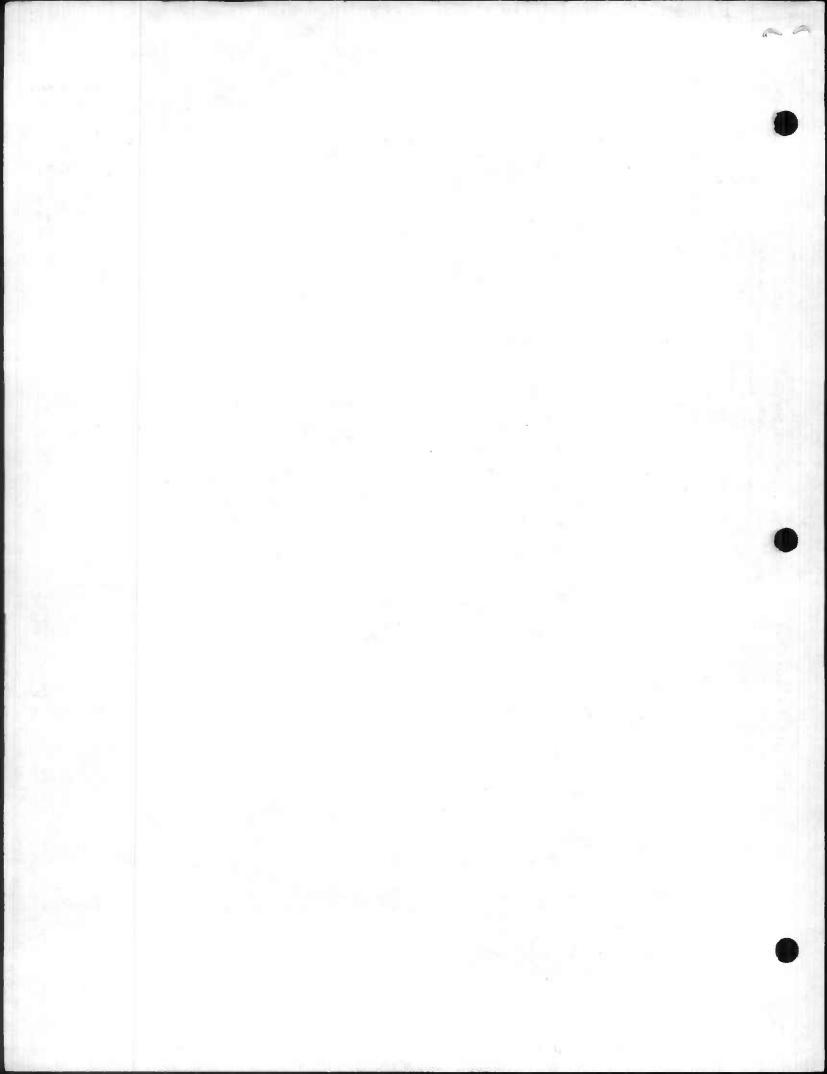
31. Dete liled (Month, Day, Year)

30. Neme and address of person who come

DHMH 16 Rev 6/95

eted cause of death (Item 23a) (Type, Print)

3001 32. Registrar's Signature



B.K.S

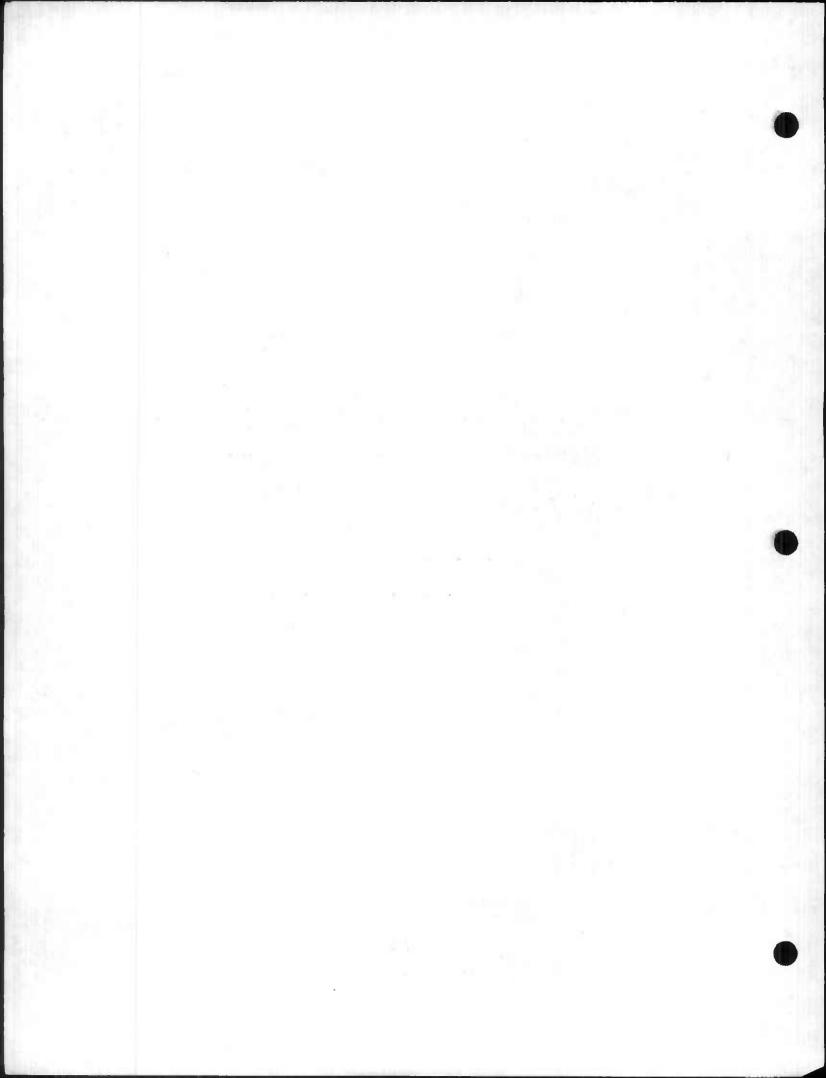
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RENEE LASHELL GREEN

State of Maryland / Department of Health and Mental Hygiene

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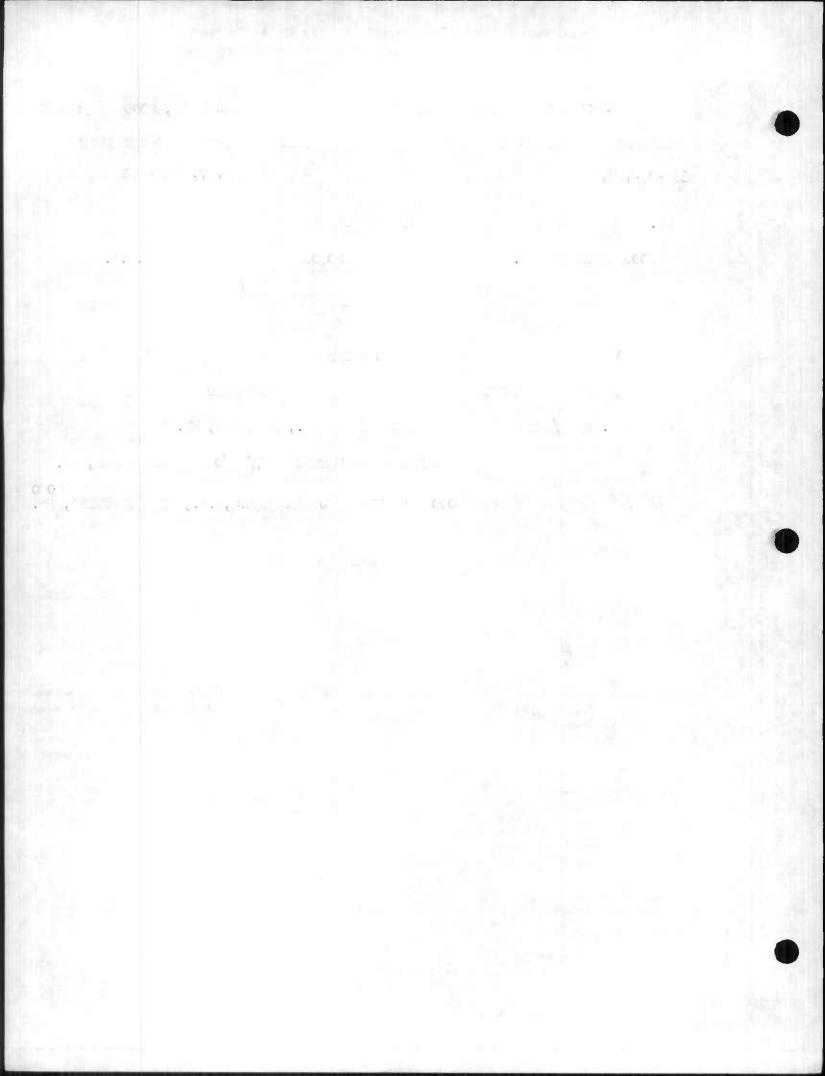
11.0	LVIII IIGOII			Certificate o	f Death		Reg. No.		2.500
	Dhualaian	1. Decedent's Nama (First, Middla, La				2. Data of De Month	ath Day	Yaar	3. Time of Death
4	Physician /Medical	RENEE L	aSHELL GREEN			JULY	23, 200		1742 PM
	Examiner	4a Facility Nama (If not institution, giv PRINCE GEORGES			4b. City, Town, or CHEVERI	CY	PRINC	CE GE	ORGES
	Funeral Director	5. Social Security Number 6. S 579-82-9525 Usual Residence of Decedant	7. Age (In yrs. I	last birthday) If Under 1 Ya Months Day			, 1965	9. Birthp Cour Was	placa (Stata or Foraign offy) Sh. DC
	Maryland a-f show filed at	10a. Stata 10b. County MD Montg		y, Town or Location Silver Spi	ing			1	1 ☐ Yas ②X No
	ufer death with the Marylan r terms 23s or 28s-f show interment to notified at Funeral Director	10e. Street and Number 3413 Chester	Wood Dr.	10f. Zip Code	20906		10g. Citizan of V		ntry?
020	urs after dealer, or Heme	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forcas? 1 Dyas 2 Mo If Yas, Give Yaar or Datas:	S. 13. Was Decedant of If Yes, specify C		Specify Yas or No to Rican, etc.)	Blad	a - Amario ck, Whita,	
2-0	led within 72 hours yglene. Nor than "natural", It, the Wooles Ess. Completed by	15. Decedant's Ed (Specify only highast gra		16a. Decedent's Usual Occ (Give kind of work dol lifa. DO NOT usa rat	cupation na during most of wo	rking	16b. Kind of B	usinass/In	dustry
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lan	Mental H Mental H arked out artic ever	Henry Green			I WHITE	Lanita	Hicks		
, Maryland 21215-0020	alth and M	19a. Informant's Name/Relationship (Yvette Green-R	**	19b. Mailing Addrass (Streer) 457 W.					
Baltimore,	permit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Important: if them 27 is marked other than "Important: if them 27 is marked other than "any Injury or other traumatic event, trained once. To Be Comple	20a. Mathod of Disposition 1 Buriat 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specif	Ramoval from Stata	laca of Disposition (Nama of amatary, cramatory or other p rest Hill (Data 3/1/00	20c. Location -		
Balti	permit. Departrimports any inju	21 Signature of Funeral Service Licer	Rolling A		trass of Facility IN FUNERALLE, MD	AL HOME			
	Physician /Medical Examiner	Immediata Cause (Final disass or condition rasulting in death)	a. Cardiac A	Arrhythmia ras a consequence of):	1		rrast,		Approximata Intarval Batwaan Onsat and Death
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit siclar/Medical Examiner	Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Dua to (or	r as a consequanca of):	ovascular	Disease			
P.0	d by the letache	Part II. Other significant conditions of	contributing to death but not rasu	ulting in tha undarlying causa	givan in Part I.		tobacco use co Yes 2□ No		the cause of death
Records,	aw requires ts been sign 2 should be pleted by						an autopsy ormed?	av	/ara autopsy findings vailable prior to omplation of causa ideath?
	cate ha	Mark Land				12	Yas 2□No	11	ØYas 2□ No
Vital	Physician: The this certificate ral director, page To Be Co	25. Was casa rafarred to medical examinar?	Hospital:		Other:	ath (Check only			
o	his his	1X Yas 2 No 27. Mapnar of Death 1 Natural 5 Panding 2 Accidant Invastigatio	28a. Data of Injury (Month, Day Year)	28b. Tima of lnjury 28c. Ir	4 ☐ Nursing I njury at Vork? ☐ Yas 2 ☐ No	Homa 5 ☐ Rasi 28d. Dascribe	danca 6 LIOth		<u>(y)</u>
Division	tal or Attending P rs after death. al Director: After t ied in by the funer. Certification:	3 Suicide 6 Could not b		oma, farm, straat, factory, offi	Ce Ce	28f. Location (City or To		ber or Run	ral Routa Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert		ysician: To the best of my knowniner: On the basis of axaminat and mannar stated.						
D	To the comp	29b. Signature and titla of centriar	taner	MD .	.C.M.E		29d. Data signe		Day, Year) 2000
		30. Nam and address of person who		1 Penn Street	, Baltimo	re, Mary	land 21	201	
	State Registrar		32. Hadistrar's Signal	B. Spour	h				



State of Maryland / Department of Health and Mental Hygiene

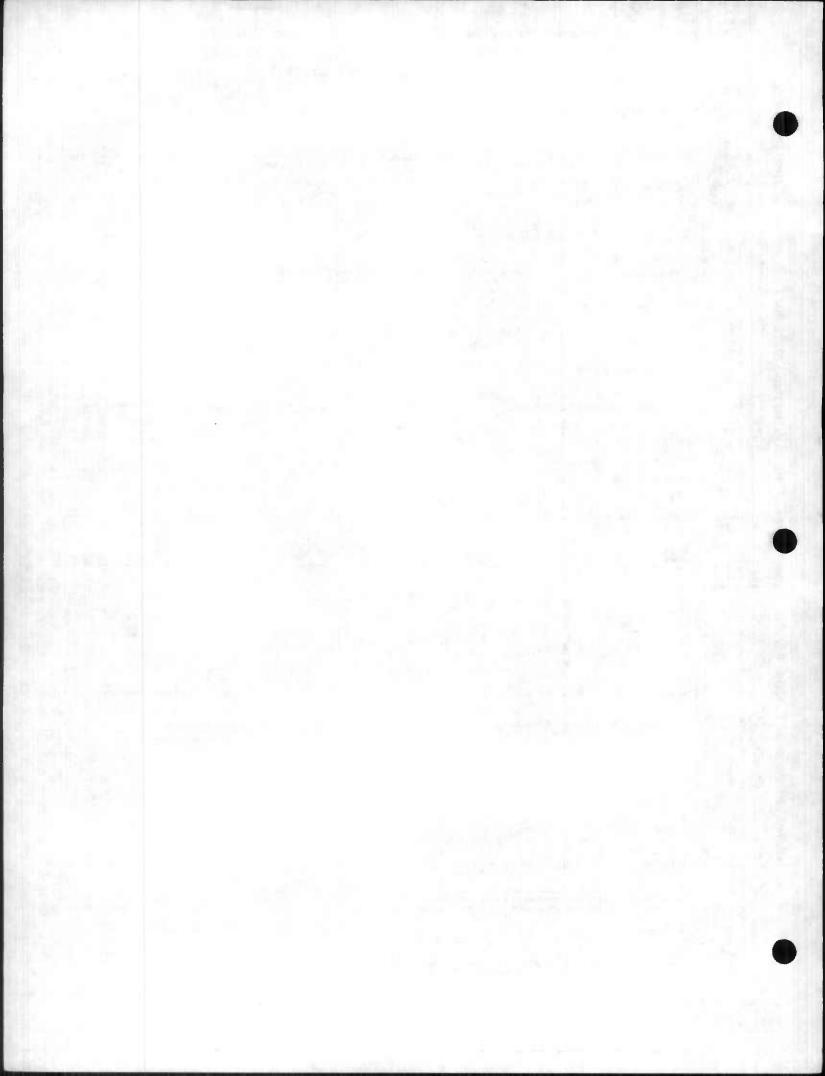
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			Ce	rtificate	of Deati	h	Re	ng. No.	0 24904
	1. Decedent's Name (First, Middle, Last)						2. Dete of Death	h Dey	3. Tima of Deeth
ysician Medical	MARGARET	THERESA	HAGE				JULY	24, 20	
niner	4a Facility Name (If not institution, give st	reet and number)			4b. City, 1	Town, or Lo	cation of Death	4c. County	of Death
	ALTHEA WOODLAND						SPRING	MOI	NTGOMERY
ral tor	352-05-7187	7. Age (In yrs	. last birthday Yrs.		Year If Under Days Hours	er 24 Hrs. Min,	8. Date of Birth (Month, Day, NOV . 7	Year) 1910	9. Birthplece (State or Foreign Country) MINNESOTA
by Funeral Director	Usuel Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or L	ocation					10d. fnslde City Limits
Director	MD. MONTGOMERY	7	SI	LVER S					1 ∑ Yes 2 □ No
Dire	10e. Street end Number			10f. Zip C	ode		10	0g. Citizen of V	Vhet Country?
	1000 DALEVIEW				20901				S.A.
by Funeral	11. Mentel Stetus 1 Never Married 2 Merrled 3 Widowed 4 Divorced	2. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	J,S. 13.	If Yes, specif	nt of Hispanic C y Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.
ted	15. Decedent's Educe	otion (atag)	16a. Dece	dent's Usuel	Occupation done during me	ant of work	Ina	16b. Kind of Bu	siness/Industry
Completed	(Specify only highest grade (Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	OST OF WORK	ing	A	TI CARTE
	17. Father's Neme (First, Middle, Last)			HOUSEW:		ther's Neme	e (First, Middle, N	Aaiden Sumem	A
Be		RUEHL							
70	HENRY 19a. Informent's Neme/Reletionship (Type		19b. Mell	ing Address (Street and Num		RGARET al Route Number	City or Town.	***
	JERALD T. HAGE/SO						HESDA. M		
)	20e. Method of Disposition	20b.	Plece of Disp	osition (Name	of	الم المال			City or Town, State
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Red 4 ☐ Donetion 5 ☐ Other (Specify)	moval from State		ematory or oth	e <i>r piace)</i> EMATORY	177	/25/00	חדות	ERDALE, MD.
n al	23a. Pert1. Enter the disease, or complice shock, or heart failure. List only one	etions that caused the dee cause on each line.	th. Do not er	iter the mode	of dying, such a	as cerdiac (or respiratory erre	est,	20906 ER SPRING, MD. Approximate Interval Between Onset and Deeth
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ysic	Pert II. Other significant conditions contr	and the same of th		underlying cau	use given in Per	rt I.		- 1	ntribute to the cause of death?
by Ph	is Chousic	ulces	3	feet			1 🗆 Y	98 2 X No	3 Probably 4 Unknown
Completed	Dement	14					24a. Wes e perform		24b. Were eutopsy findings eveileble prior to completion of ceuse of death?
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Be	25. Wes cese referred to medicet exeminer?				1 -	ace of Deet	h (Check only on	e)	
To Be	1 ☐ Yes 2 ◯XNo		ER/Outpetie			Nursing Ho	me 5 Reside		
Medical Certification:	27. Menner of Deeth 1 Deturel 5 Pending Investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time Injury	of 286	c. Injury at Work?	□No	28d. Describe ho	ow injury occur	red
Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - At the building, etc. (Special Control of the building) and the building of the buildin	nome, ferm, s ify)	treet, fectory,	office		28f. Location (St City or Town		er or Rural Route Number,
edical	29a. Certifier (Check only one)	cian: To the best of my know; On the basis of examination and menner steted.	owledge, dea etion and/or in	th occurred et nvestigetion, is	the time, dete n my opinion, d	end place, leeth occurr	and due to the co red et the time, d	euse(s) and ma ate end place,	nner as stated. and due to the cause(s)
2	29b. Signature and title of certifier	HEROTER PL		29c.	License numbe	er	2	9d. Dete signe	d (Month, Day, Year)
1	phian	0		D	2670	7		7-2	4-00
	30. Name and address of person who com	pleted cause of deeth (Ite	m 23a) (Type	, Print)		/	Α.	1	15 D 2090 /
	TUNG Di Lee, M	700	Bucki	nghinn	Drive.	- Sit	ven S	oxing	15 D -0 /
State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	eture 4	100	· Val		/	0	



			State of Ma	aryland		rtificate of	Death	wentai ny	Reg. No.	00	24985	
Physicia /Medic		1. Decedent's Neme (First, Middle Christopher D.		. Chu	ing Do	Hahm		2. Dete of D Month July	Dev	Year	3. Time of Deeth 11:55PM	
Examin	_	4e Facility Neme (If not Institution	give street end number)		1145		4b. City, Town, or L	ocation of Dea	th 4c. Count	y of Deeth		
'V}		Suburban Hospit					Bethesda			gomer		
Funeral Director		5. Social Security Number 576-70-4524	6. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. la 7	st birthday) Yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Oct. 2	6, 1924		place (State or Foreign ntry) rea	
death with the Maryland rms 23a or 28a-f show rmust be notified at		Usuet Residence of Decedent 10e. Stete 10b. County		10c. City	Town or Lo	ocation					10d. Inside City Limits	
Mar mined	50	Maryland Montgo	omery	187	Bet	hesda					1 ☐ Yes 2 No	
or 28	Sign of	10e. Street and Number				10f. Zip Code			10g. Citizen of	Whet Cou	ntry?	
23a	ra	7701 Woodmont					814		United			
P 2 2	by Funeral Director	11. Meritel Status 1 Never Married 2 Merri 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Detes:			Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	dispenic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		eck, White	can Indien, , etc. sian	
72 ho	ted	15. Decedent (Specify only highes			16a. Dece	dent's Usuei Occup	oation during most of work	kina	16b. Kind of E	Business/Ir	ndustry	
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filed v Hygie ther t	3	17. Father's Neme (First, Middle, I	5+			Trader	18. Mother's Nen	ne (First Middl		ding		
ould be Mental	To Be	Il Bong Hahm					Sun Ja					
2 should and Meniarke	-	19e. Informent's Name/Relationsh	ip (Type, Print)		19b. Meill	ng Address (Street	and Number or Ru		ber, City or Town	n, State, Zi	p Code)	
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of Hem		20a. Method of Disposition 1 Ñ Buriel 2 ☐ Cremetion	2 Demousi from State	20b. Pic	ece of Disponentery, cre	osition (Name of metory or other pla	ce)	Dete	20c. Location - City or Town, Stata			
Peges ant: If its		4 Donetion 5 Other (Sp		Nor	beck :	Memorial	Park	7/22/00	Olne	y, MD	, MD	
permit. Peges 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiens I natural; or important: If item 27 is marked other than "natural; or any injury or other traumatic event, in Medical Examples.		21. Signeture of Funeral Service to	licensee DoMs		H		ldi Funer			Princ	g, MD 20904	
DALL!		23a. Pert1. Enter the disease, or shock, or heert feilure. List of	complications that caused only one ceuse on each ii	the deeth							Approximete Intervel Between	
Physician /Medical Examiner		Immediate Cause (Final disease or condition	e. End Sta	age L:	iver I)isease					Onset and Death 2 Years	
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or Attending after death. I Director: After d in by the fune	ertific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Pleca of inj building, et	ury - At hoi c. (Specify	me, ferm, st	reet, fectory, office		28f. Location City or T	(Street end Nun own, Stete)	n <i>ber</i> o <i>r R</i> u	rel Route Number,	
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To the To the	/ Me	29b. Signature and title of certifier	V. H	tten	ding	29c. Licen	se number		29d. Date sign	ned (Month	, Dey, Year)	
50	+	30. Name and address of person v	who completed cause of	Dhy deeth (Item	23e) (Type	D400 Print))78		July 19	9, 20	00	
		Daniel I. Kim,	MD 121 Con	gress	ional	Lane Roo	kville,	MD 2085	2			
Stat Registra		31. Dete filed (Month, Day, Year)	32. Registr	er's Signet	G.	Spork						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Year Physician 9 AM 20, 2000 ANNE JULY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Montgomery 9039 Sligo Creek Parkway If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birtholace (State or Foreign 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 10 M 20 F NewYork 90 FEB 17, 1910 Director 075.16.8519 Usual Rasidence of Deceden the Maryland 10d. Insida City Limits 10c. City. Town or Location 10e. Stata 10b. County 28a-f show e filed within 72 hours after death with the Marylas at Hygiens or the same 23a or 28a-f ahow other than "natural", or from 23a or 28a-f ahow vent, the Madred Examine main be notified a 1 Yas 2 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 United States 9039 Sligo Creek Parkway Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White by 35 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher traumatic avent, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked other any Injury or other traumatic avent once. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) "Unknown" Fannie Gelman Louis 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1860 Upshur St. NW Washington, DC 20011 19a. Informant's Name/Ralationship (Type, Print) Louise Kavruck/ Daughter 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Surial 2 Cremetion 3 Removal from Steta King David Memorial Garden 07/23/00 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licen 22. Name end Address of Facility Stein Hebrew Memorial Funeral Home 232 Carroll St. NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** tmmediata Causa (Finat disease or condition rasulting in death) /Medical Hypertension 20 yrs. Examiner

the attending physician end hed for use as the burial-transit

signed by the

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After this funeral

To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

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Completed

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Medical Certification:

Box 68760

P.O. |

of Vital Records,

Division

The law requires that the death certificate be

Physician/Medical Examiner

Dua to (or as a consequence of): Due to (or as a consequence of) Dua to (or as a consequence of)

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yas 2 No 5 Residence 6 Other (Specify) 28a. Date of fnjury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation Netural 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 6 ☐ Could not be 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha time, data end place, and dua to the cause(s) and manner stated. 29e. Certifier

(Check only one) 29b. Signature and title of certific

MD D47654

29c. License number

29d. Date signed (Month, Dey, Year) 7/21/00.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

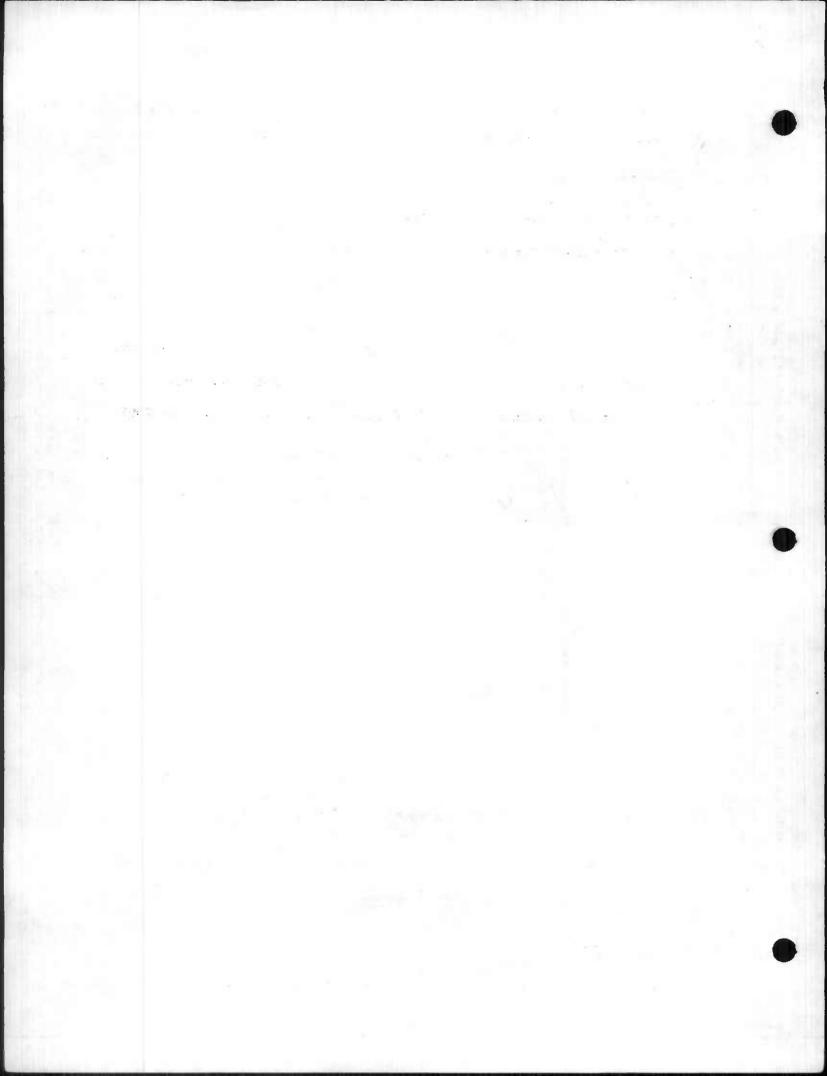
6525 Belcret Rd Ste 160 Hyattsville MO Charlotte Kvatt, MD 31. Data filed (Month, Day, Year)

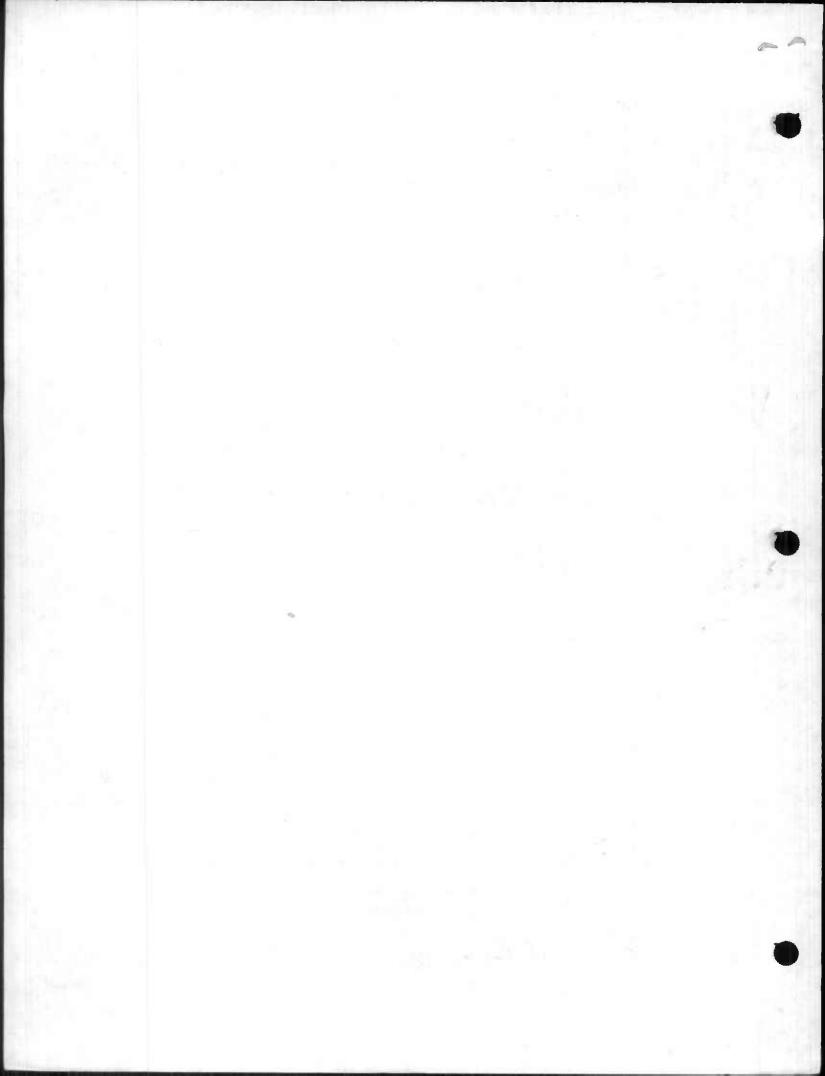
State Registrar

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32. Registrar's Signature





State of Maryland / Department of Health and Mental Hygiene 00 24988

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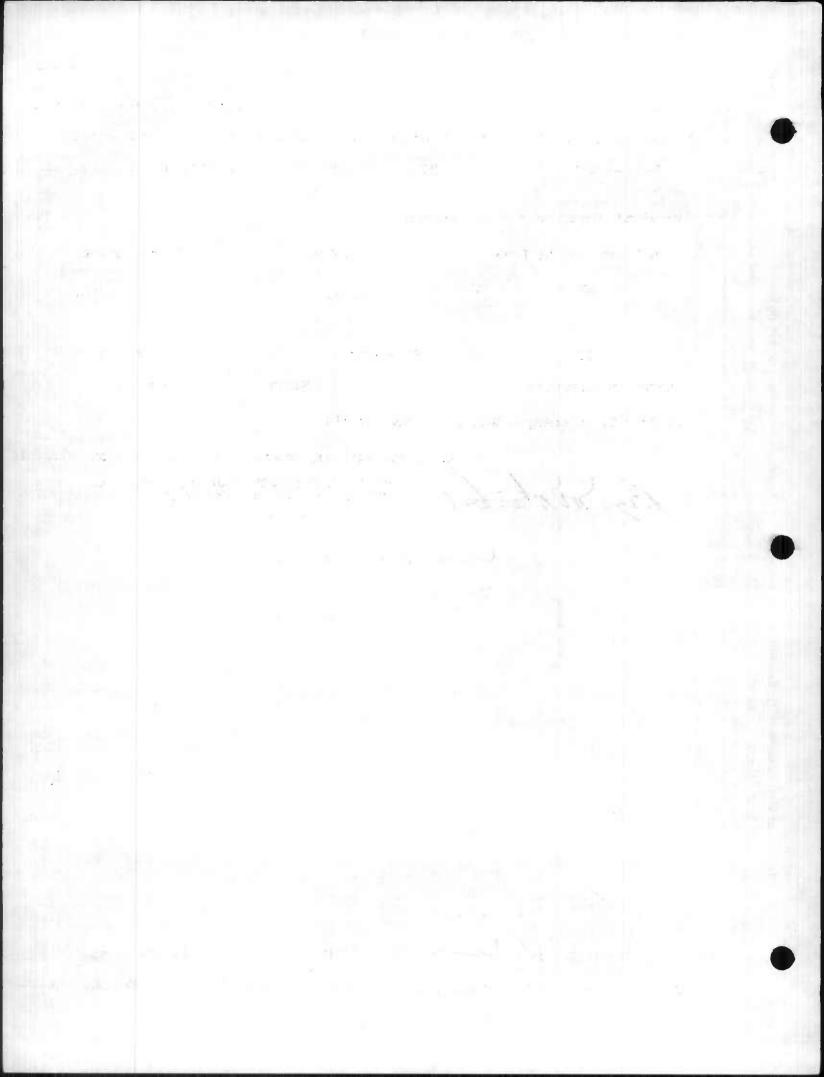
29d. Dete signed (Month, Dey, Year)

State Registrar

29b. Signeture and title of certifier

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Régistrer's Signeture



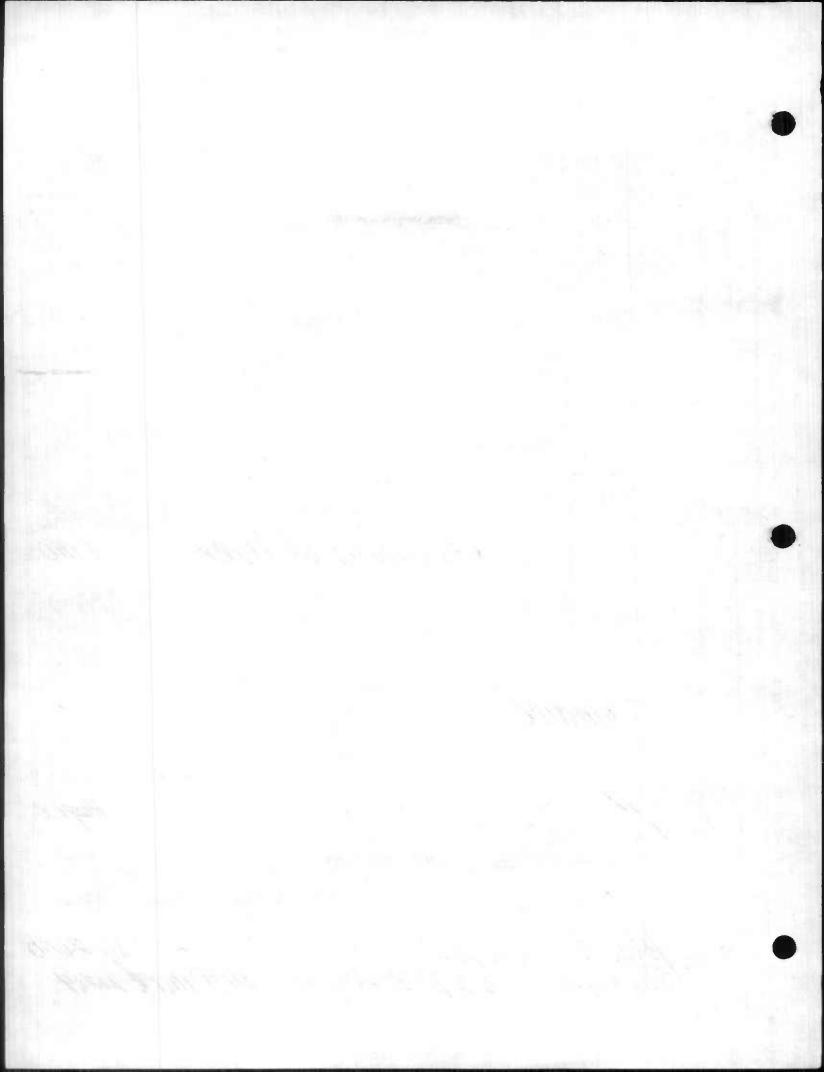
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 2000 Month **Physician** July 23, ELLEN V. HOPKINS 4:42 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 828 Eutaw Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. OCT. 8, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 20F Washington, D.C 78 Yrs. 577-20-6517 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow 1 Yes 2 No Director Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8118 Allendale Drive 20785 Herns 23s United States Funeral . Wes Decedent Ever in U,S. Armed Forces?
1 Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 natural', or Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Etementery/Secondery (0-12) 12 College (1-4or 5+) Accountant Technician Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health end Mental Important: If item 27 is marked or any injury or other traumatic eve John Moses Payne Ruby Allen 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Donald G. Hopkins Son 8118 Allendale Drive, Landover, MD 20b. Place of Disposition (Name of cematery, cremetory or other place) 20e. Method of Disposition Deta 20c. Location - City or Town, State 7/31/2000 1 NBurial 2 Cramation 3 Ramoval from Stata Maryland Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funerel Service Licensae McGuire Funeral Service, Inc. Werre 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sect line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finet disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted avents resulting in death) Lest Due to (or as a consequence of): the Dua to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed page 2 should 24a. Wes en eutopsy 1 Yes 2 No certificate 1 TYes 2 TNo Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6XXOther (Specific Medical Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o this 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28c. Injury at Work? Attending Division 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) filled in by or A efter 4 | Homicide To the Hospital or within 24 hours eff To the Funeral DI compietely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted. 29e. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 0013012 31. Dete filed (Month, De State

Registrar

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123



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** Hopkins 12:32am Henry Clyde July 22 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) **Examiner** Olney Montgomery General Hospital Montgomery 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 8. Date of Birth April 20, 1914 Sanington DC 5. Social Security Number **Funeral** 1 M 2□ F 578-01-7957 86 Yrs. **Director** Usuel Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any lijury or other treumatic event, the Medical Expriner must be notified at once. 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20905 2012 Cradock St. United States Funerai 12. Wes Decedent Ever in U,S. Agmed Forces? 11 Yes, 2 □ No ff Yes, Give Year or Detes: WWII Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritel Status Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Title Insurance Researcher 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Henry I. Hopkins Florence Yeatman To 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 6926 Hanover Parkway #403 Greenbelt, MD 20770 Barbara Hopkins/ Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 0 Oakwood Cemetery 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 07/25/00 Falls Church, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signety49 of Funeral Service License 22. Name end Address of Fecility Pearson Funeral Home 472 N. Washington St. Falls Church, VA 22046 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsel and Deeth Physician /Medical Immediate Cause (Final CARDIAC ARREST diseese or condition resulting in death) Examiner CONGESTIVE HEART FAILURE Examiner physician and the bunal-transit certificate be executed Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediale cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest ATRIAL FIBRILLATION Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) as EPSIS usa Pol signed by the a Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No director 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpetient 2 □ ER/Outpetlent 3 □ DOA 2 funeral 27. Menner of Death
10 Neturel
2 Accident 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homlcide ò 24 hours 8 Hospital 1 Certifying Physicfen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steted. 29e. Certifier Medical (Check only one) To the Vithin 2 29c. License number 29d. Dele signed (Month, Dey, Year) 29b. Signeture end title of cartifier M.D., Ph.D. D0055054 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) REDLAND ROAD, ROCKVILLE D 32. Registrar's Signature 31. Date filed (Month, Day, Yeer) State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Jamon 4b. City, Town, or Location of Death 4c County of Death 4a Facility Name (If not Institution, giva street end number) 7. Age (In yrs. lest birthday) If Under 24 Hrs. 8, D 5. Social Security Number ce If Undar 1 Yaar 9. Birthplace (Stete or Country) 8. Date of Birth (Month, Dev. Year) Months Days Hours 1₩ 2□ F 0 Yrs N/A July 24,2000 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ☐ No LaPlata Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 U.S.A. 9641 Kline Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S Armed Forces? 11. Marifal Status 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married 1 Yes 2 No Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Schalonda Deltraiese Jackson Rashad Jamal Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) 9641 Kline Dr. LaPlata, MD 20646 Schalonda Jackson/Mother 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date Brinsfield-Echols 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/27/00 Charlotte Hall, MD 1 Home PA AREHART - ECHOLS Funeral 21. Signature of Funerel Service Licensee FUNERAL HOME, P.A. ENGL MO0945 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that ceused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Non Viable Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Entar Undarfying Cause (Disease or injury that inflieted events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? 2000 3 Probably 4 Unknown 1 Yes

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Pages 1 and 2

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Baltimore, Maryland 21215-0020

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To the Hospital within 24 hours a To the Funeral C

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The law requires that the death certificate be executed and

Physician/Medical Examiner use as the burial-transit the attending physician ate has been signed by the a Be Completed by After this certificate has Director: After this certific d in by the funeral director, To Medical Certification:

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

examiner?	46
27. Manner of Death	
1 Natural	5 Pendin

investigation 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29e. Cartifier

2 Accident

3 ☐ Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stafed.

29b. Signature and title of certified

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29c. License number 8 D 5 G 3 3 4 6 2

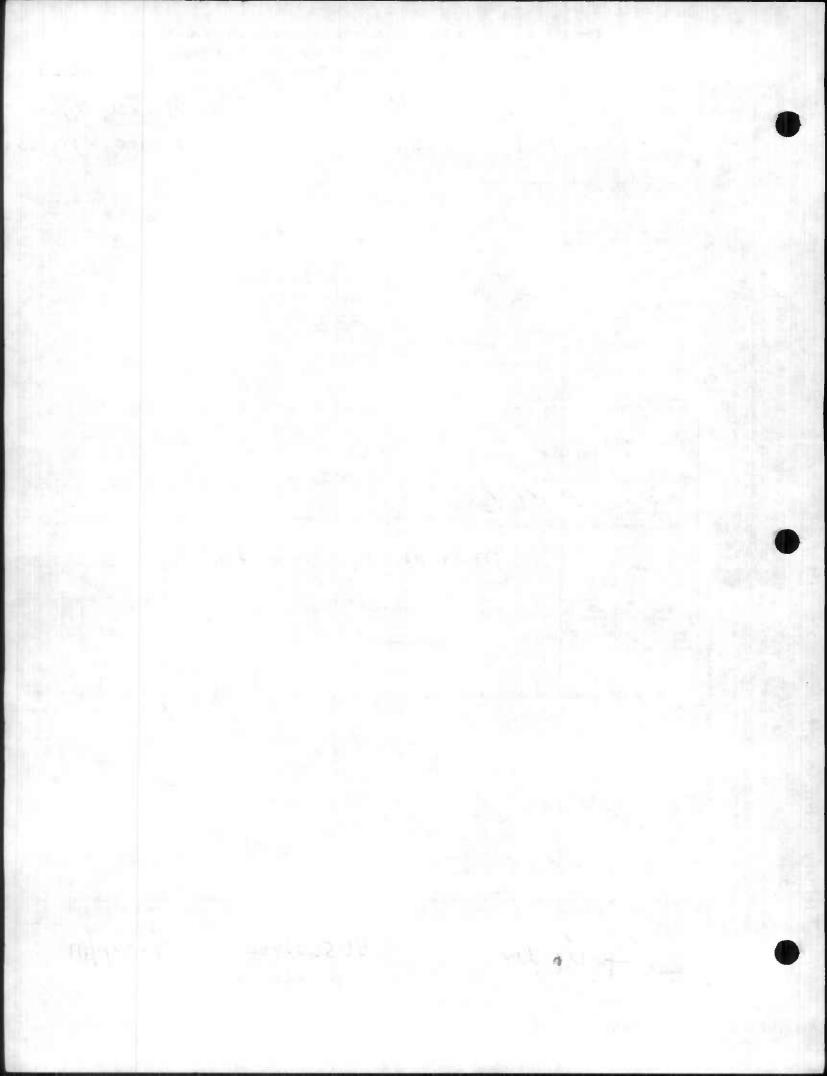
29d. Date signed (Month, Day, (Year)

o. Name and address of person with completed ceuse of death (Item 23s) (Type, Print) Nicholus Donkor, M.D. 7009 Jewell Hands Circle, Columbia, MD 21044 31. Date filed (Month, Dey, Year)

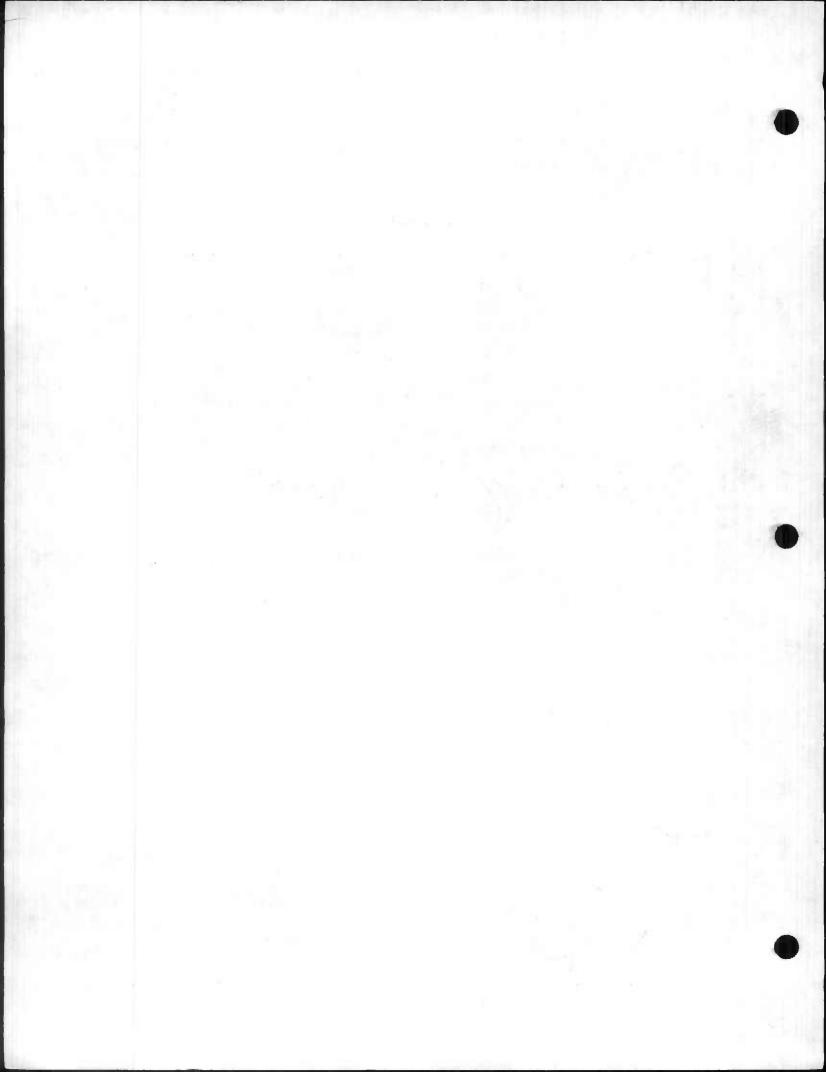
32. Registrar's Signature

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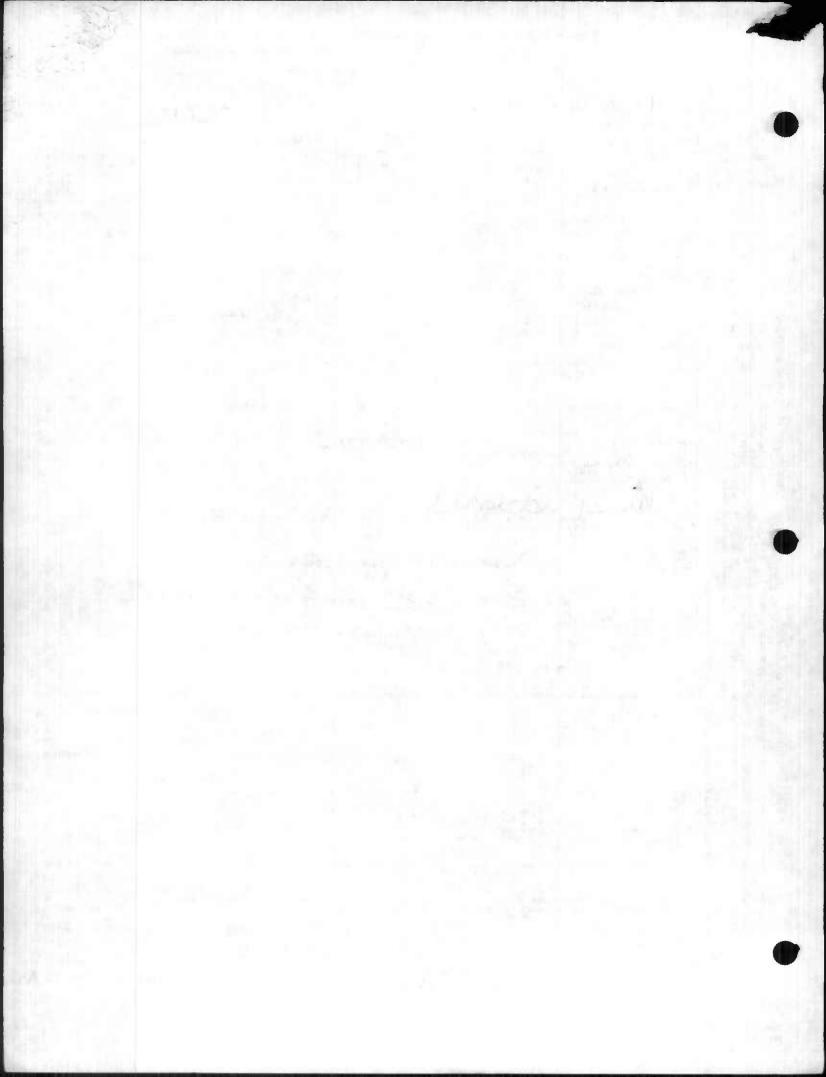
State Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** July 23, Virginia Eveline Ingraham 2000 12:05pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpleca (Stete or Foreign Country) **Funeral** Days 1□M 2⊠F Yrs. 79 Director 468-16-5327 June 6, 1921 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28s-f show 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code or frems 23s or a Funeral 401 Russell Avenue #610 20877 United States 12. Was Decedent Ever in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hybjane. Introductant if fleen 37 is marked other than "natural; or he any follow yo other traumptic event, the Medical Examples any follow or other traumptic event, the Medical Examples. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: à 3 ☐ Widowed 4 ₺ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Elbert Ray Pickett Mayme McConochy 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loring J. Ingraham (Son) 20102 Timber oak Lane, Germantown, MD 20874 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State Metropolitan Crematory 7/24/00 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Nema end Address of Fecility DeVol Funeral Home 21. Signeture of Funeral Service Licenses 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete thtervel Between Onset end Death **Physician** Immediate Cause (Finel /Medical etastatic disease or condition resulting in death) carcinoma, smal car Examiner Due to (or es e consequenca of): The law requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as e consequence of) usa as the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? detached been signed by should be detac 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings evsilable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? has certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical axaminer? 80 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, data and placa, and dua to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Ave, Garthersburg Mc cven 0 105 mo 31. Date filed (Month, Day, Year) Registrer's Signeture State JUL 24 Registrar



Amended #2	, 7/27/2000, per M.	State of Maryland				U	0 24993		
Physician /Medical	1. Decedent's Nama (First, Middle, Last Dolo Thy	Jarvi'e			2. Date of De Month	Reg. No. ath Day 2000	Yaar 1:50 A-		
Examiner Funeral Director	4a Facility Name (If not institution, give Prince Cearger's 5. Social Security Number 171-32-7153	Hospital C	st birthday) If Und			PC	9. Birthplaca (Stata or Foreig Country) Indiana, PA		
	Usual Residence of Decedent 10a, Stata 10b, County	100 Chu	Town or Location						
death with the Maryland ms 23s or 28s-f show prost be notified at ner al Director			iverdale	Heights			10d. Inside City Limits 1 ☐ Yas 2 ☑ No		
vith the Market services	10e. Street and Number			ip Code		10g. Citizen of W	21		
23a ov	5904 Roanoke Aven	ue	20	737		USA			
urs efter	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	13. Was Dec If Yes, sp	edent of Hispanic Origin? (ecity Cuban, Mexicen, Pue	Specify Yes or No rto Rican, etc.)	- 14. Raca Black Specify:	- Amarican Indian, , Whita, etc. White		
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Mentel Hygi marked other atic event, I	17. Father's Name (First, Middle, Last) James Medora				ma (First, Middle, thy Hann)		
and N	19a. Informant's Name/Ralationship (7)			ss (Street and Number or F					
ages 1 and ont of Health t: If Nem 27 y or other tr	William Jarvie - 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Pla Removal from State Chu	ca of Disposition (N	ame of other place)	Date	20c. Location - C	ights, MD 207 City or Town, State		
permit. Pag Department Important: I eny Injury c	21. Signature of Funeral Service Licens	neral Se	24/00 Cherryhill Twp., PA ral Service, Inc. Alexadnria, VA 22310						
cardificate be assecuted and use as the bunkal-transit and AMedical Examiner	disaasa or condition rasulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or influry that initiated evants rasulting in death) Last	Due to (or so	as a consequence of the same as a consequence of as a consequence of as a consequence of	in sheli	med in	y.			
death d for a	Part II. Other significant conditions con	d	ing in the underlying	causa given in Part I.	23b. Did	tobacco uas con	tribute to the cause of deat		
signed by the					10	Yes 2 No	3 □ Probably 4 M Unkno		
aw require been 2 shou					24a. Was	an autopsy ormed?	24b. Ware autopsy findings available prior to completion of causa of death?		
cate he					10	Yes 22No	1 ☐ Yes 2 ☐ No		
Physicien: The this certificate ral director, pag.: To Be Co	25. Was case referred to medical examiner?	Hospital:	B/Outpationt 2□ (Other	eath (Check only		e (Engelist)		
	27. Mannar of Death 1 Natural 5 Pending 2 Accident investigation		1 Inpatient 2 EH/Outpatient 3 DOA 4			Home 5 Rasidance 6 Other (Specify) 28d. Describe how injury occurred			
न्या में	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, atc. (Specify)	ne, farm, street, facto		28f. Location (Street and Number or Rural Route Number, City or Town, Stata)				
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my knowle ner: On tha basis of examinatio and manner stated.	edge, death occurre on and/or investigation	d at the tima, data and place on, in my opinion, daath occ	ce, and dua to the curred at the time,	d dua to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)			
To the company	29b. Signatura and title of certifier			9c. License number			(Month, Day, Year)		
6	18h	Roll	M.D	D00541	40	1 pire chererly, MD 2			
State Registrar	30. Name and address of person who con Shervin Rahv 31. Date filed (Month, Day, Year)			3001 HOSPI	tal nive	cher	erly, mi) 207		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 20, Jordan 2000 Byron 3:25 pm /Medical 4c. County of Death Anne Arundel 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arnold 1190 Mosswood Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 25, 1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 1 XM 2 F 90 Yrs. 214-03-5966 Georgia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-! show the Medical Examiner must be notified at Anne Arundel Arnold MD 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 21012 1190 Mosswood Court USA 238 Hems 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status of thysiene.

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other than "natural", or the 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 XMarried Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White þ f Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Equipment Óperator Equipment 12 Department of Health and Mentel Hy Important If Hem 27 is marked other any injury or other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abraham Jordan Lula Jane Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Jordan/ wife 1190 Mosswood Court, Arnold, MD 21012 20b. Placa of Disposition (Name of cametery, crematory or other place)
Oak Grove Cemetery 20c. Location - City or Town, State 20a, Method of Disposition July 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Iron State Glenwood, 2000 4 Donation 5 Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 art1. Enter the disea Do not enter the mode of dying, auch as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition /Medical Examine DNUC Exam Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part tl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 100 signed by 1 Yes 2 No 3 Probably 4 Unknown by Records, Completed 24b. Were autopsy findings 24a. Was an autopsy available prior to completion of cause of death? performed' 1 ☐ Yes 28 No 1 Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200No 10 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of edical Certification: Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29b. Signature and Illie

John

29a. Certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

son who completed cause of death (Item 23a) (Type, Rrint) and addrass of

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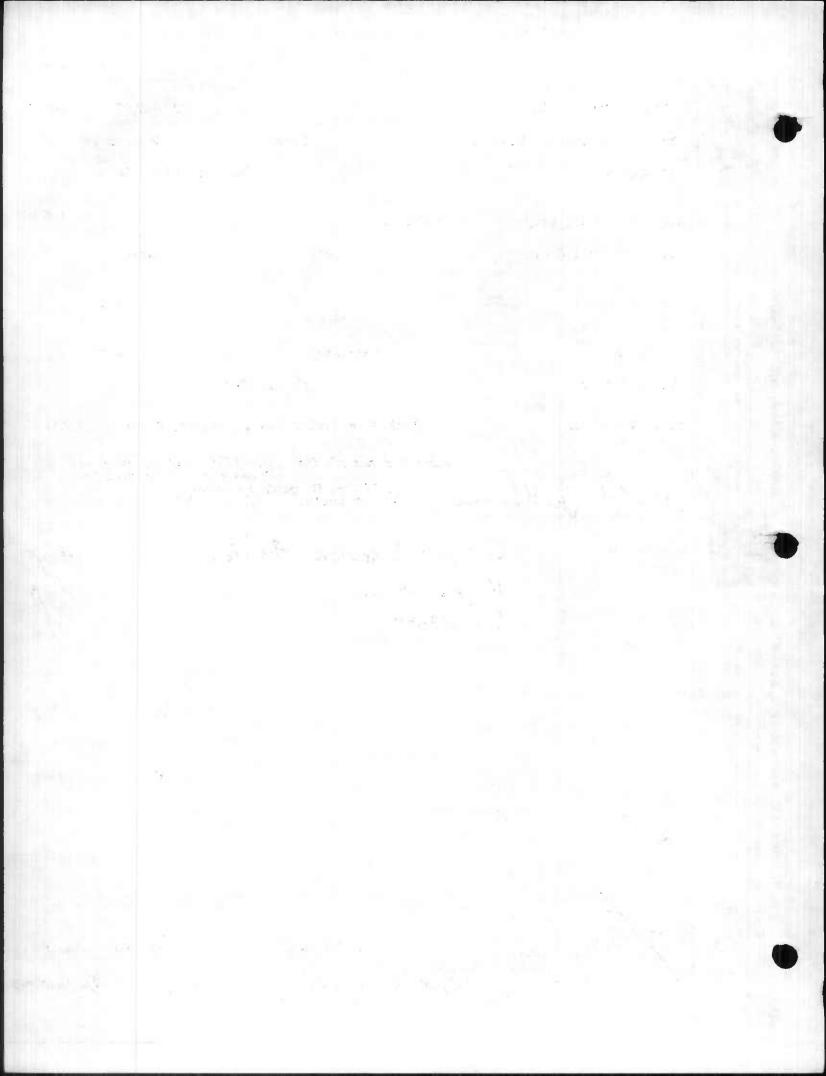
29c. License number 29d, Date signed (Month, Day, Year)

Registrar

ALLES DIE CHARLES AND ASSESSED.

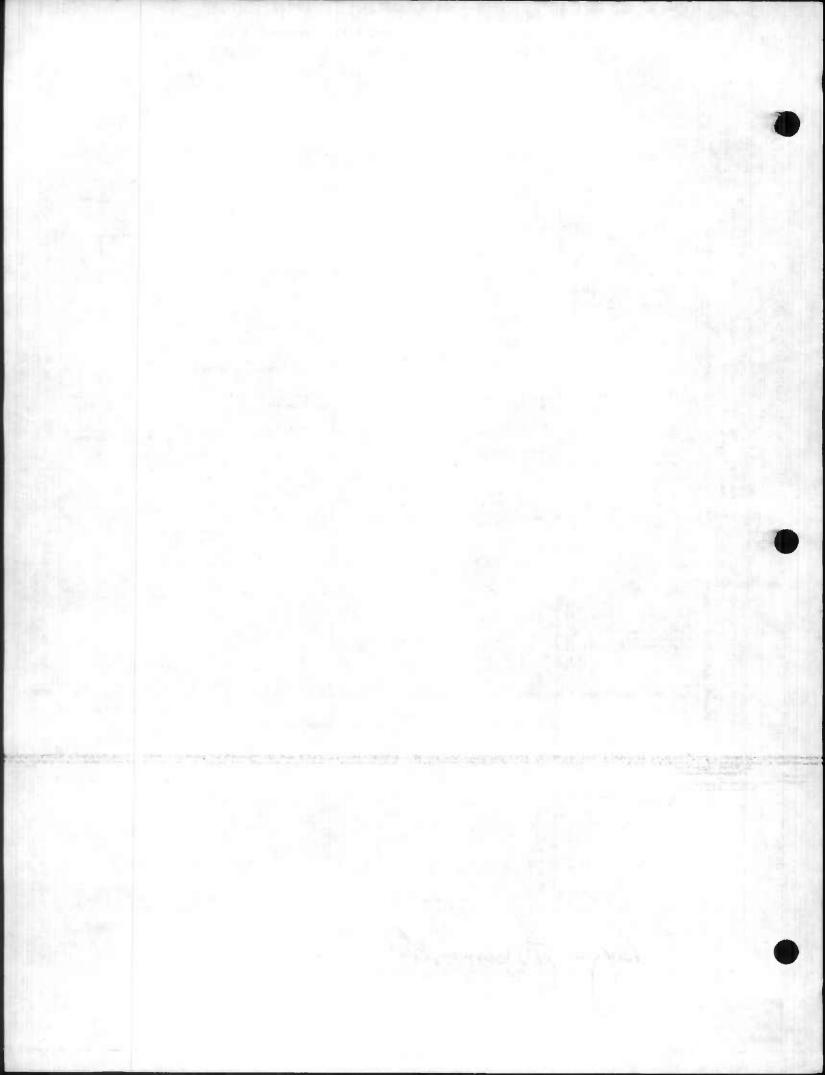
State of Maryland / Department of Health and Mental Hygiene 00 24995

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	1. Decedent's Name (First, Middle						2. Dete of Dee Month	eth Dey	Year	3. Time of Death				
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iner	4a Facility Neme (If not institution	The state of the s							cation of Death	4c. County	of Deeth			
	Montgomery Gen	eral Hospit	tal				01ne				tgome			
	5. Social Security Number 214-86-0814	6. Sex 1 □ M 2 ▼ F	Age (In yrs. la 84	st birthday) Yrs.	If Under Months	1 Yeer Deys	If Under 2 Hours	Min	8. Date of Birth (Month, Day Sep. 7,	v. Year)	9. Birtho Cour Chir	place (State or Foreign htry) 1.a.		
1	Usual Residence of Decedent 10e. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits		
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Director	10e. Street end Number	omery	Roc	-1C V I I I	10f. Zip	Code		-		10g. Citizen of	Whet Cour	ntry?		
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	11. Maritel Status 1 □ Never Married 2 □ Merr 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 ff Yes, Give Year or Dete	s? No		Wes Deced			in? (Spe Puerto I	ocify Yes or No- Rican, etc.)	14. Rad Bla Specif	ck, White,			
l	15. Deceden	's Education		16e. Deced	dent's Usue	Occup	pation			16b. Kind of B	usiness/In	dustry		
	(Specify only highes	College (1-4d	or 5+)	life. I	DO NOT us	e retire	eation during most d)	or workii	ng					
l	Elementery/Secondery (0-12)				Home	mak	er			Ow	n Hon	ne		
	17. Fether's Neme (First, Middle,									Maiden Sumar	ne)			
	Chang Whan Pan						Oak E	Bun (Chung					
	19e. Informant's Name/Relations	nlp (Type, Print)		19b. Mellin	ng Address	(Street	end Number	r or Rura	I Route Numbe	er, City or Town	, State, Zip	Code)		
	In S. Kim / Son						ylor I	ane				a 20171		
1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 □Removel from State	cer	nce of Dispo metery, crer	sition (Name metory or of	ne of ther pla	ce)		Dete	20c. Location	- City or To	own, Stete		
l	4 Donetion 5 Other (S		Nor	beck 1	Memor	ial	Park	07/	28/00	Olney,	Mary	Maryland		
1	21. Signature of Fundral Strictor	joensee								ıldi Fui	neral	Home		
11800 New Hampshire Avenue Silver Spring, Maryland 20904														
7	23n Pert1. Enter the disease, or shock, or heart feilure. List	complications that caus	ed the deeth.							rest,		Approximete Interval Between		
									,			Onset end Death		
disease or condition a Cerebral Vascular Accident											5 days			
	resulting in death)			es e consec								2		
ı		- H	. Dee	ten	SION						i	Schars		
Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause Disease or injury: that initiated owners.										1				
									1					
	that initiated events resulting in death) Last		Due to (or a	as a conseq	quence of):						1			
Cause (Disease of Injury that initiated events as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Y														
l														
4	Pert II. Other significant condition	ns contributing to death	to death but not resulting in the underlying cause given in Pert I.					23b. Did (23b. Did tobacco use contribute to the cause of des					
l									10	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
										en eutopsy rmed?	av cc	fere autopsy findings veileble prior to ompletion of cause death?		
									101	res 2 No	1	☐ Yes 2☐ No		
	25. Was case referred to medical						26 Place	of Dooth	(Check only o		1	20.00		
90 0	examiner?	Hospital.	tion. OFF	R/Outpetier	a	Oth	or			dence 6 □Ot	(C	M1		
9	27. Manner of Death	1 X Inpa		28b. Time of		A	4 1401			now injury occu		19)		
Ceruncation:	1 Natural 5 Pendin		Day Year)	Injury	М	8c. Injui Wo: 1 □								
	3 Suicide 6 Could determine	home, ferm, street, factory, office 28f. Location (Street and Number or Rural Route No. City or Town, Stete) 28f. Location (Street and Number or Rural Route No. City or Town, Stete)						al Route Number,						
Medical		g Physician: To the bes												
3	one)	end menner		on one of the										
-	29b. Signated and Atle of ografie	1.1					se number			29d. Dete signo				
	13/1/60	the				5/	1908 Mary			July	25	2000 Magliarium		
1	30. Name end eddress of person	who completed gause o	f deeth (Item :	23e) (Type,	Print)/		1	,	0	1.	1 1			
	18111 HRING	Whillis	D. D.	10 C	1/40	الم	Wke	1/4	ne V	Callet	18	Machinen		
ite	31. Dete filed (Month, Day, Xear)	2000 32. Resi	strer's Signatu	1re 4	1	1	/	1		2010		7-9-1910		

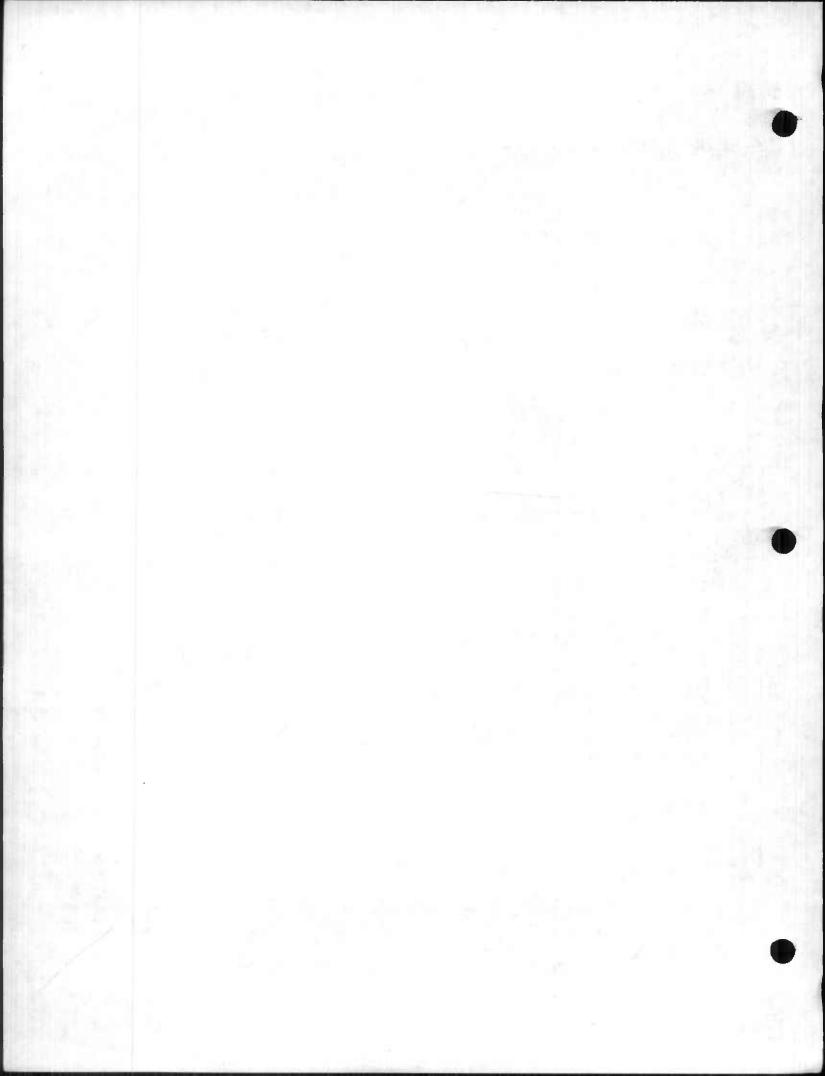


State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death		Reg. No.	IU	24996
	Dharistan	1. Decedent's Name (First, Midd	die, Last)					2. Date of Dea	ath Day	Yeer	3. Time of Deeth
-	Physician /Medical	Metro	Krenitsky					July	24, 200	0	8:00 am
	Examiner	4a Facility Nema (If not institute	on, give street and number	7)			4b. City, Town, or L		4c. County	of Death	
		Brooke Grove N 5. Social Security Number		iga (In yrs. last biri	thdou) If Unde	er 1 Yaar	Sandy Spr	ing	Montgo	omery	nco /State or Engains
	Funeral Director	203-03-5739	1∭ M 2□ F		Yrs. Months		Hours Min.	8. Date of Birt (Month, Da) Nov 8,			ace (Stata or Foreign ry) sylvania
۱,	Director	Usuel Residence of Decedent						NOV 0,	1920	1 elilli	sylvania
100	ahow dat	10a. Steta 10b. Count	у	10c. City, Town	n or Location					10	od. Inside City Limits 1 ☐ Yes 2 🖾 No
	or 28e-fr be notified Directo	Maryland Montg	omery	Brooke					40 000 444		
	Die Be	10e. Street and Number				ip Code			10g. Citizen of V	vnat Count	try /
	after death with the Maryla or hams 23a or 23a-f shor infeer must be notified at r Funeral Director	22311 Flintrid	ge Drive	t Evar in U.S.		833 edent of F	Hispanic Origin? (Sa	pecify Yes or No	USA 14. Raci	e - Amarica	an Indian,
0	Fun Fun	1 □ Never Married 2 Ma	Armed Forces	No 1942-			Hispanic Origin? (St an, Mexican, Puerto	o Rican, atc.)		k, White, e	
00	D Ex	3 ☐ Widowed 4 ☐ Divorce	od If Yes, Give Yaar or Detes	1945	1 Li Yes	2∭ No	Specify:		Specify	Whi	te
200	led within 72 ho yglens. wer than "naturn it, the Medical Completed	15. Decede (Specify only high	nt's Education est grada complated)	16e.	Decedent's Us (Give kind of w	uel Occup ork done	pation during most of world)	king	16b. Kind of Bu		
121	mpl m	Elemantary/Secondery (0-12)	College (1-4or						DC Meta Police	-	
9	Hyger Hyger Co	10 17. Fether's Neme (First, Middle	o, Last)	ре	rective	гте	utenant 18. Mother's Nam	ne (First, Middle,			I CHIEII C
lan	Mental H Mental H srksd oth stic ever	Phillip Krenit	skv				Emily E	lalchak			
Maryland 21215-0020	and M	19e. Informent's Neme/Reletion		19b	. Mailing Addre	ss (Street	end Number or Ru		er, City or Town,	State, Zip	Code)
III 2504	Health Health other tra	Alice B. Kreni	tsky / Wife	22	311 Fli	ntri	dge Drive	, Brook			
Baltimore,	C delight	20a. Method of Disposition 1 □XBurial 2 □ Cremation	a 3 □Removel from Stet		Disposition (No. 1) Disposition (No. 1) Disposition (No. 1)	eme of other ple	(e)	Dete	20c. Location -	City or Tov	wn, State
Ë	Pa dury	4 Donetion 5 Other ((Specify)	Park1	_		1 Park	7/27/00	Rockvil	lle, l	MD
Bal	Separation of the separation o	21. Signature of Funeral Service	e Licansee		Franci	end Addre	Collins	Funeral	Home,	Inc.	
	40200	23a. Pert I: Enter the disease, of	WG Col	e	500 Un	iver	sity Blvd	I., W, S	ilver Sr		MD 20901 Approximete
		shock, or heart failure. Lis	st only the cause on each	line.	not enter the mi	ode of dyl	ng, such as cardiac	or respiratory a	rest,	1	Intervel Between Onset end Deeth
2	Physician /Medical	Immediate Cause (Final	0 1	1							
	Examiner	disease or condition resulting in deeth)	e. Cerebr	ovascula Due to (or as e							6 months
	F E		_ Arteri	100			scular Di	sease			vears
	tificate be executed up physician and as the buriel-transit ledical Examiner	Sequentially list conditions,		Due to (or as e	consequenca of	i):		-			THE REAL PROPERTY.
68760,	be ey burie	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.								
687	g physician and as the buriel-trar	rasulting in death) Last	Part Control	Due to (or as a d	consequance of):					
	the death certified by the attending letached for use a Physician/M		d					- A			No.
	es that the death certioned by the attendine be detached for use by Physician/N	Pert II. Other significant condit	tions contributing to death	but not resulting in	n tha underlying	cause gi	ven in Pert I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
P.O.	that the red by the detache							10	Yes 2 No	3 Prob	pably 4 Unknown
Ś.	be be by	TOTAL PLAN								T 0.45 W-	
Records,	been sign should be								an autopsy rmed?	ava	ere autopsy tindings allable prior to appletion of cause
Rec	has pe 2										iesth?
= '	ilcian: The law requir certificate has been si rector, page 2 should be Completed	25. Wes case referred to medic	al la				26. Place of Dee		Yes 20XNo	1 1 L	Yes 2 No
Vital	3 0 5 0	exeminer?	Hospitel: 1 Inpa	tient 2 ER/Ou	Itpatient 3 0	OOA Ot			dence 6 □Oth	er (Specify	()
	g Physical distriction on: To	27. Manner of Death 1 ○Natural 5 □ Pend	28e. Dete of In		Time of njury	28c. Inju Wo			how injury occur		
Sion	Attanding r death. sctor: Atte by the fune liftcatior	2 Accident inves	itigetion		M		Yes 2□No				
	tal or Attanding P rs after death. al Director: After ti ed in by the funera Certification:		mined 250. Pleca of I	njury - At home, fa etc. <i>(Specify)</i>	irm, street, facto	ory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rura	I Route Number,
	Ports a	29e. Certifier 1 XCertify	ing Physician: To the bes	t of my knowledge	donth coourre	d at the ti	imo, dato and alace	and due to the	course(s) and me	nance on et	etad
	thin 24 hour thin 24 hour thin 24 hour thin 24 hour mpletely fill		Examiner: On the basis	of examinetion an stated.	d/or investigation	on, in my	opinion, death occu	rred et the time,	date end placa,	end due to	the cause(s)
	To the Hooptal or Attanding Privation 24 hours after death. completely filled in by the funeral Completely filled in by the funeral Medical Certification:	29b. Signature and file of certifi	- 11				se number		29d. Dete signe		
	15	1 Sexan	- XInu	rusi. 1	D	083	81		July 24,	2000	0
	19.	30. Neme and address of purson	n who completed cause of	deeth (Item 23a)	(Type, Print)						
	0.										
	State	Benjamin Avrun		1 Prince		Dri	ve, Olney	, MD 2	0832		



	State of Maryland / Department of Health and N Certificate of Death		Reg. No.	0 24997				
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Moe Katz	2. Dete of De Month July	Dey 24, 2	Yeer 000 10:39 AM				
Examiner Funeral Director	4b. City, Town, or Lot SHADY GROVE ADVENTIST HOSPITAL ROCKVI 5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M Onths Deys Hours Min.	LLE	of Birth th, Dey, Year) MONTGOMERY 9. Birthplece (State of Country)					
	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location	11911	-, 1910	10d. Inside City Limits				
or 28a-f st encored	MD Montgomery Montgomery Village 10e. Street end Number 10f. Zip Code		10g. Citizen of W	1 ☐ Yes 2% No Thet Country?				
within 72 hours effer death with the Maryland ene. than "natural; or items 23s or 28s-f show he Medical Evaniner must be notified at ampleted by Funeral Director	18700 Walker's Choice Rd., Apt 421 11. Meritel Status 1 □ Never Merried 2 □ Married 1 □ Never Merried 2 □ Married 3 및 Widowed 4 □ Divorced 1 □ Ves Cive 1 □ Yes 2 □ No 1 □ Yes 2 □ No	ecify Yes or No Rican, etc.)	Bleck	- American Indien, k, White, etc.				
led within 72 hours effort the "natural", or not then "natural", or nt. if the Medical Eventh Completed by F	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) 12 College (1-4or 5+) Furrier	ing	16b. Kind of Bu					
Mental Hyg riked other ric event,	17. Father's Name (First, Middle, Last) Charles Katz 18. Mother's Name	e (First, Middle, da Rose		θ)				
nd 2 should be file with and Mental Hy 27 is marked other r traumatic event	19a. Informent's Neme/Reletionship (Type, Print) Dana Sitnick/ daughter 19b. Mailing Address (Street and Number or Run 6271 Park Rd., McLean			State, Zip Code)				
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the made. To Be Compl	20a. Method of Disposition 20b. Pleca of Disposition (Name of	uly 26, 2000		City or Town, State				
permit. Departi Importi any Inj ang Inj	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, MD							
Physician /Medical Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. Acute Arrhythmia Due to (or as a consequence of):			Intervel Between Onset end Death unknown				
sath certificate be executed attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of):							
the day	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld		ntribute to the cause of death				
requires the been signed should be defeed by	Heart Failure	24e. Wes	Yes 2 No	24b. Were eutopsy findings aveilable prior to completion of cause of death?				
certificate has rector, page 2			Yes 2⊠No	1 🗆 Yes 2 🗆 No				
tel or Attending Physician: This safer death. In Director: After this certificate led in by the funeral director, page Certification: To Be Co	exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 27. Menner of Death 1 Neturel 5 Pending (Month, Day Year) 28b. Time of Injury 2 Accident Investigation	h (Check only one) me 5 Residenca 8 Other (Specify) 28d. Describe how injury occurred						
ital or Att urs after d ral Direct illed in by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)						
To the Hospital or within 24 hours after To the Funeral Dir completaly filled in O Medical Ceri	29e. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, (Check only one) 12 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occur end manner steted. 29b. Signeture and little or certifier 29c. License number D53887		dete end placa,	and due to the ceuse(s) d (Month, Day, Year)				
State Registrar	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Orlee Panitch, MD 9901 Medical Center Drive, Rockvil 31. Dete filed (Month, Day, Year) 1111 2.8 2000	le, MD	20850					



			State	of Maryland		artment o			nd M	lental Hy	giene	nn	21.	000
		Decedent's Nama (First, Middle, Last)								2. Date of Death				me of Death
	Physician	Raymond Leroy K	ina							July 2	.6. 20	Year	Q	:10 am
10	/Medical	4a Facility Name (If not institution		umber)			4	b. City. Toy	m, or Lo	ocation of Deal		ounty of Deat		. 10 alli
	Examiner	Prince George's												
		5. Social Security Number		7. Aga (In yrs. las	t hirthday)	If Under 1 Y		hever		8. Data of Bi		ince G		
١.	Funeral		6. Sex 14 M 2 □ F	77	Yrs.		ays	Hours	Min.	(Month, D	ay, Year)	Co	intry)	tate or Foreign
	Director	548-26-9303 Usual Rasidence of Decedent		11						Oct 4,	1922	Cal	ifor	nia
	pue A	10a. Stata 10b. County		10c. City,	Town or Lo	cation							10d. Ins	ide City Limits
	Aaryl Sho	W11 D	0			114								Yas 2 No
	vith the Ma to or 28a-1 s be noutled	Maryland Prince	George	s New	carro	11ton	Ai				10 011			
	within 72 hours after death with the Maryland ene. Than "ratural", or heme 23e or 28e4's show the Madical Examiner mant be notified at propleted by Funeral Director	8424 Carrollton	Parkway			10f. Zip Co					USA	of What Co	anery r	
	ther death v	11. Marital Status	12. Was De	cedant Ever in U,S.	13.	Was Deceden	t of Hi	ispanic Orig	in? (Sp	ecify Yes or N Rican, etc.)	0- 14.	Race - Ame		en,
0	五 音 图	1 Never Married 2 Man	Armed F	2 No 1942		1 □ Yes 2			Puento	rucan, etc.)		Black, White	, etc.	
02	by	3 ☐ Widowed 4 ☐ Divorced		IIV (I		1∟ Yes 24L) No	Specify:			Sį	pecify:	White	e
Q	2 ho	15. Deceden	t's Education		16a. Dece	dent's Usual C)ccupi	ation		01/2 H	16b. Kind	of Business/I	ndustry	
215	ple ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work of DO NOT use i	ione d	lunng most)	of work	ing				
21215-0020	No. of Participants	Liementary/Secondary (0-12)			Profe	ssor					Educ	ation		
	be filed within 72 ho tal Hygiene. d other than "naturn event, me Hed call Be Completed	17. Fathar's Name (First, Middle,	Last)					18. Mother	's Name	9 (First, Middle				
a	Mental Me	William C. King						Merc	edes	s D. Be	cker			
2	d 2 should be filed within in the end Mental Hygiene. The marked other than "traumatic event, fre. His	19a. Informant's Name/Ralations			19b. Mailing Address (Street and Numb							own State 2	in Code)	
Maryland	14 P													
a)	THE D	Valentine King / Son 46 Cockrell Avenue, Alexandria, VA 22304 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)									Town St	ate		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Department of Health and Menta Introportant; If item 27 is marked any injury or other traumatic avoides.	Burial 2 Cramation		1 Stata					t	8/2	200. 2000	ion ony or	Own, Ou	510
	tmer tant jury	4 Donation 5 Othar (S		Mary.	-	Vetera				2000	Che1	tenham	, MD	
<u>a</u>	epar ny in	21. Signatura of Funaral Sarvice	Licensee			Name and A				Funera	1 Home	Tnc		
	20548	James S	Wooder	n						d., W,				MD 2090
		23a Parti Enter the disaasa, or shock A haart failura. List	complications that	caused the death.	Do not ent	ar the mode o	f dyin	g, such as o	ardiac	or respiratory	arrest,	DPIL	Appro	ximata at Between
1	Physician	minor, of flaatt tailura. List	Only One Cedse On	eedi iire.								1		and Death
	/Medical	Immediata Causa (Final disaasa or condition		h								1		
	Examiner	rasulting in daath)	a	Due to (or e								1		
	je je			9 (O) (O) 40 G	s a conse	juence orj.						!		
	te be executed tysicien and he buriel-trensit	Comment to the state of the state of	b. —	Dua to for a		usono of):						I		
,	be executed icien and burlal-trensit													
/60,	ysicie e bur													
	Phy S the	resulting in death) Last		Dua to (or as	s a consec	uence of):						1		
	ontifica nding ph use as th		d											
ROX	v requires that the deeth certifical been signed by the ettending phy should be detached for use as the should be detached for use as the leted by Physician/Medi													
5	the d	Part II. Other significant condition	ns contributing to	death but not resulti	ng in the u	nderlying caus	ise given in Part t. 23b. Did				d tobacco use contribute to the cause of de			
7	deta deta	CHRONIC OBSTRUCTIVE PRIMONEN							1 11	y 10	Yes 2	No 3□Pr	obably	4X Unknow
Hecords,	signe d be d			mentia enebral arteriose lerosis							24b 1	More aut	opsy findings	
0	negu houli		De man	t, a							s an autopsy ormed?	-8	eldaliave	
ec	law las b s 2 s npi											1	of death?	0. 04500
	sician: The law require certificata has been si irector, page 2 should be Completed		Cereb	12/ ant	lerio	sc les	05	11		10	Yes 2 X	No ·	□ Yas	20 No
VITAI	elen: octor, Be (25. Was case referred to medical axaminar?						26. Place	of Deat	h (Check only	one)			
>	5 00	1 Yas 2 No	Hospital:	Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
0	2 2 2	27. Mannar of Death	28a. Data		3b. Time o		Injun			28d. Describe				
ō	tending P Jeath. tor: After the funer the funer Ication:	1 Netural 5 ☐ Pandin 2 ☐ Accident investig	M	mi, Day (ear)	Injury	м		Yes 2 N	lo					
DIVISION	or Attending after death. Director: Afte I in by the fune ertification	3 ☐ Suicide 6 ☐ Could I	ined 288. Piec	e of Injury - At home	a, farm, str	eet, factory, o	ffice			28f. Location		lumber or Ru	ral Route	Number,
5	245ª	4 ☐ Homicide datarm	build	ling, etc. (Specify)						City or To	iwn, Stete)			
	Hospital or 24 hours after Funerel Dir etely filled in dical Cert	29a. Cartifiar 1 Certifyin	g Physician: To the	a best of my knowle	dge, deat	occurred at t	he tim	e, date and	place	and due to the	cause(s) ar	d menner as	stated	
	Hotely dic	(Check only 2 Medicat one)	Examiner: On tha t	pasis of examinetion	and/or in	vestigation, in	my of	oinion, deat	h occum	ed at the time	data and pl	ace, and due	to the ca	iuse(s)

15+1

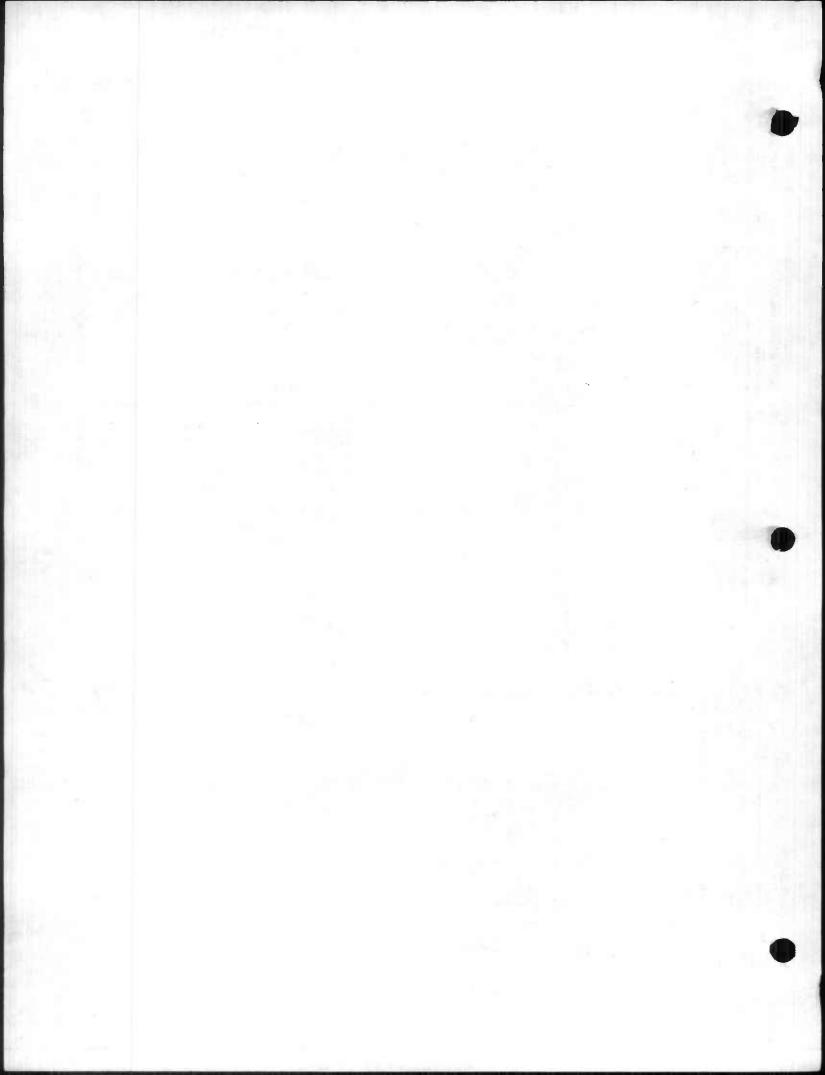
29c. License number

D 0 5 8 9 7 29d. Data signed (Month, Day, Year) July 28, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Roger B. Ingham, MD
31. Data filed (Month, Day, Year) 6510 Kenilworth Ave, Riverdale, MD 20737

State Registrar

JUL 2 8 2000

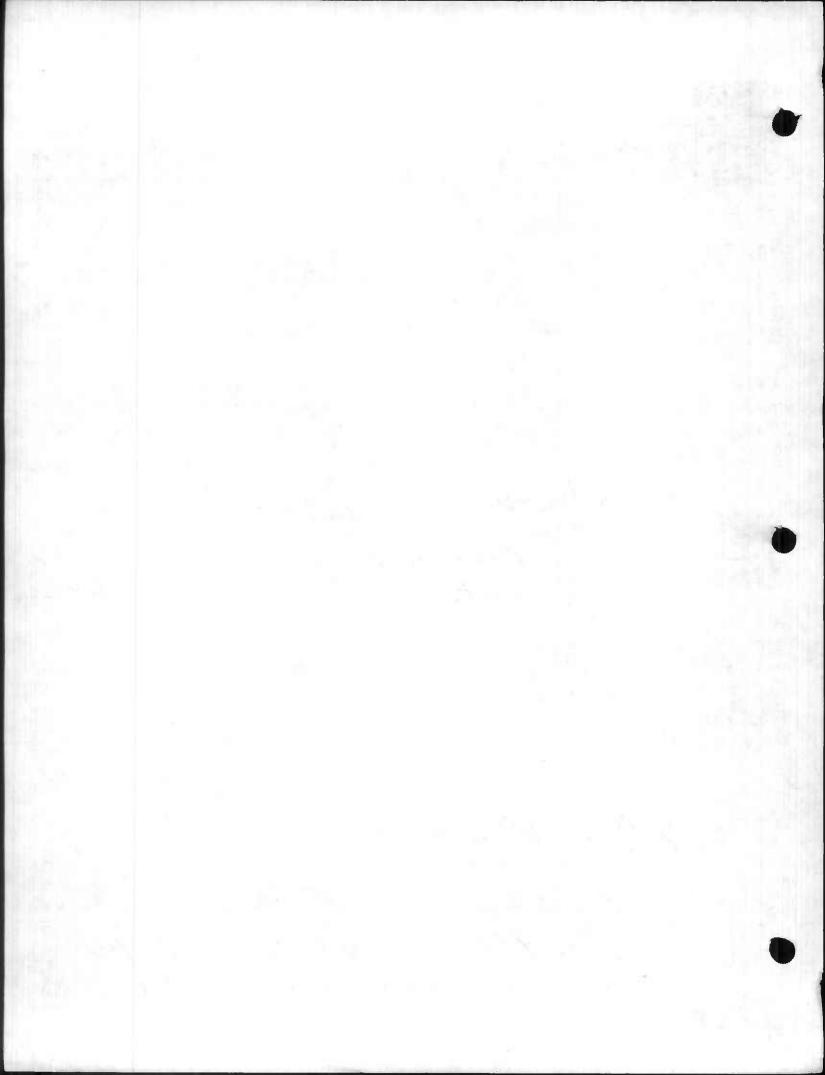
32. Registrer's Signetura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** William . Howard July **Kinsley** 25 2000 11:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facifity Nama (If not institution, giva street end number) Examiner Frederick Memorial Hospital Frederick If Under 24 Hrs. Frederick 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** Min Months Days Hours Yrs. 235-22-4452 Director 75 May 23, 1925 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ XNo Director Frederick Maryland Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 238 11530 Hessong Bridge Road 21788 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Bfack, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Datas: 1 Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16h Kind of Business/Industry filed within Elementary/Secondery (0-12) Coflege (1-4or 5+) Hygiene. Owner Kinsley Appliances 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be es 1 and 2 should be fi of Health and Mental H I flem 27 is marked off r other traumetic ever Samuel Kinsley Bessie Huffman 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Myrtle Maxine Kinsley/Wife 11530 Hessong Bridge Rd., Thurmont, Md. 21788 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages I ¶ Buriaf 2 ☐ Cremation 3 ☐ Removal from State ä 4 ☐ Donation 5 ☐ Othar (Specify) Resthaven Memorial Gardens7/29/00 Frederick, Maryland 22. Name and Address of Facility
MONEY & KING VIENNA FUNERAL HOME, INC. 21. Signature of Funaral Service Licensae Ě 134/201 171 W. Maple Ave., Vienna, Va. 22180 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one ceuse on eech line. Approximate nterval Bety Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical neumania Examiner Due to (or as a consequence of): Physician/Medical Examine Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury Due to (or as a consequence of): that the death certificate be execu Box 68760. thet initieted events resulting in death) Last Dua to (or as a consequenca of): 100 88 use P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco uas contributa to the causs of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings available prior to completion of cause of death? 2 should 24a. Was an autopsy Be Completed page 1 Yes 1 ☐ Yes of Vital 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2D Certification: To Inpatient 2 ER/Outpatient 3 DOA this nger of Deat 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division To the Hospital or Attending Neturat 2 Accident 5 Pending Investigation tnjury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and affie of pertifier 29d. Date signed (Month, Dey, Year) 29c. Licensa number 0 se of deeth (ftem 23a) (Typa, Print eric 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Persone JUL 28

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 27, Constance Stuart Larrabee 2000 5:30 p.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heron Point - #311 Heron Point Chestertown Kent Hours Min. 8. Date of Birth (Month, Day, Year) August 7, 1914 5. Social Security Number If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 1 M 2 XF 577-48-0262 85 Yrs Director England Usual Rasidance of Dacedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show enty fujury or other treumstic event, the Medical Examinar must be notified at onde. 10d. Inside City Limits 1 Yes 2 No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 #311 Heron Point USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yas, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photographer Photography 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Alan Stuart Elizabeth Anne Benetts 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 226 Calvert St., Chestertown, Maryland 21620 Joan W. Merryman 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 7/28/2000 Stevensville, Maryland 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility Fellows, Helienbein & Newnam funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Ceuse (Finel 54 ndrome 5 years poventi attor disease or condition resulting in death) Examiner Examine respiratory attending physicien and for use es the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lest Due to (or es a conse Birth Division of Vital Records, P.O. Box 68760 Dua to (or as a consequence of): Physician/Medical ate has been signed by the a page 2 should be deteched t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes grano 3 Probably 4 Unknown py 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? is certificate I 1 ☐ Yes & No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home SPAesidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) Certification: 28c. Injury et Work? 27. Magner of Deeth 28d. Describe how injury occurred 28b. Time of 1- Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homiclde

Registrar

To the Hosp within 24 hou To the Fune completely fi

Jugan 31. Date filed (Month, Dey, Year) 2 8 2000

29a. Certifier

(Check only one)

29b. Signature end title of certifie

Medical

mD. 5/6 Washington 32. Registrer's Signatur

mD

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted.

29c. License number

29d. Date signed (Month, Day, Year)

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